

SERFF Tracking Number: MCHX-126415671 State: Arkansas  
 Filing Company: Time Insurance Company State Tracking Number: 44308  
 Company Tracking Number: 8035.POL.AR  
 TOI: H10I Individual Health - Dental Sub-TOI: H10I.000 Health - Dental  
 Product Name: 8079.POL.XX Individual Dental Indemnity Policy - T  
 Project Name/Number: 8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company /8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company

## Filing at a Glance

Company: Time Insurance Company

Product Name: 8079.POL.XX Individual Dental SERFF Tr Num: MCHX-126415671 State: Arkansas  
 Indemnity Policy - T

TOI: H10I Individual Health - Dental

SERFF Status: Closed-Approved- State Tr Num: 44308  
 Closed

Sub-TOI: H10I.000 Health - Dental

Co Tr Num: 8035.POL.AR

State Status: Approved-Closed

Filing Type: Form/Rate

Author: SPI McHughConsulting

Reviewer(s): Rosalind Minor

Date Submitted: 12/10/2009

Disposition Date: 01/26/2010

Disposition Status: Approved-  
 Closed

Implementation Date Requested: 01/10/2010

Implementation Date:

State Filing Description:

## General Information

Project Name: 8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company Status of Filing in Domicile: Pending

Project Number: 8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 01/26/2010

Explanation for Other Group Market Type:

State Status Changed: 01/26/2010

Deemer Date:

Created By: SPI McHughConsulting

Submitted By: SPI McHughConsulting

Corresponding Filing Tracking Number:

Filing Description:

Time Insurance Company

NAIC # 69477 FEIN # 39-0658730

Individual Dental Indemnity Policy

8079.POL.AR, et al - Policy

See Attached Form Listing

|                                 |   |                               |                                 |
|---------------------------------|---|-------------------------------|---------------------------------|
| <i>SERFF Tracking Number:</i>   | <i>MCHX-126415671</i>   | <i>State:</i>                 | <i>Arkansas</i>                 |
| <i>Filing Company:</i>          | <i>Time Insurance Company</i>   | <i>State Tracking Number:</i> | <i>44308</i>                    |
| <i>Company Tracking Number:</i> | <i>8035.POL.AR</i>  |                               |                                 |
| <i>TOI:</i>                     | <i>H101 Individual Health - Dental</i>  | <i>Sub-TOI:</i>               | <i>H101.000 Health - Dental</i> |
| <i>Product Name:</i>            | <i>8079.POL.XX Individual Dental Indemnity Policy - T</i>   |                               |                                 |
| <i>Project Name/Number:</i>     | <i>8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company /8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company</i> |                               |                                 |

McHugh Consulting Resources, Inc. has been requested to file the attached forms on behalf of Time Insurance Company. We have provided an authorization letter for your files.

We are submitting the above captioned forms and rates for your review seeking approval. The forms are new and not intended to replace any other forms currently in use.

This Dental program will be marketed to individuals through agent/broker solicitation. This plan will be offered using the applications herewith submitted or as an integrated offer with other plans using previously filed application or enrollment forms. This program is being concurrently filed in the domicile state of Wisconsin. This dental plan provides indemnity benefits when specified dental procedures are rendered. The scheduled benefit amount for each covered procedure is shown on the Policy Schedule. This plan does not include PPO benefits.

Please note that the Policy is numbered using a matrix format, where each section of the document has a unique form number. For example, the Policy face page is numbered 8079.POL.AR, while the Exclusions section of the same document is numbered 8079.EXC.XX. The Company employs this form numbered style for administrative and tracking purposes. The Policy will always be issued in its entirety with all sections and form numbers included.

These forms are subject to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. Variable data or text is bracketed and a variability statement is enclosed herewith. Variable data will never exclude provisions required by applicable law.

Attached please find any required certifications and/or transmittal forms and filing fees. Please do not hesitate to contact the undersigned at (215) 230-7960 if there are any questions I can answer regarding this filing.

## **Company and Contact**

### **Filing Contact Information**

|                                  |                          |
|----------------------------------|--------------------------|
| Jane Neal, Compliance Assistant  | mcr@mchughconsulting.com |
| McHugh Consulting Resources      | 215-230-7960 [Phone]     |
| 350 South Main Street, Suite 103 | 215-230-7961 [FAX]       |
| Doylestown, PA 18901             |                          |

### **Filing Company Information**

(This filing was made by a third party - McHughConsulting)

|                             |                         |                              |
|-----------------------------|-------------------------|------------------------------|
| Time Insurance Company      | CoCode: 69477           | State of Domicile: Wisconsin |
| 501 West Michigan Avenue    | Group Code: 19          | Company Type:                |
| Milwaukee, WI 53201-0624    | Group Name:             | State ID Number:             |
| (414) 299-1140 ext. [Phone] | FEIN Number: 39-0658730 |                              |

SERFF Tracking Number: MCHX-126415671 State: Arkansas  
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Time Insurance Company

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## Filing Fees

Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? No  
Fee Explanation:  
Per Company: No

| COMPANY                | AMOUNT  | DATE PROCESSED | TRANSACTION # |
|------------------------|---------|----------------|---------------|
| Time Insurance Company | \$50.00 | 12/10/2009     | 32685753      |

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## Correspondence Summary

### Dispositions

| Status          | Created By     | Created On | Date Submitted |
|-----------------|----------------|------------|----------------|
| Approved-Closed | Rosalind Minor | 01/26/2010 | 01/26/2010     |
| Approved-Closed | Rosalind Minor | 01/26/2010 | 01/26/2010     |
| Approved-Closed | Rosalind Minor | 12/28/2009 | 12/28/2009     |

### Objection Letters and Response Letters

| Objection Letters         |                |            |                | Response Letters     |            |                |
|---------------------------|----------------|------------|----------------|----------------------|------------|----------------|
| Status                    | Created By     | Created On | Date Submitted | Responded By         | Created On | Date Submitted |
| Pending Industry Response | Rosalind Minor | 12/15/2009 | 12/15/2009     | SPI McHughConsulting | 12/23/2009 | 12/23/2009     |

### Amendments

| Schedule   | Schedule Item Name                    | Created By           | Created On | Date Submitted |
|------------|---------------------------------------|----------------------|------------|----------------|
| Form       | Benefit Summary-Dental Insurance      | SPI McHughConsulting | 01/26/2010 | 01/26/2010     |
| Form       | Benefit Summary-Dental Insurance      | SPI McHughConsulting | 01/26/2010 | 01/26/2010     |
| Supporting | 8079.BNS.XX - Redlined with revisions | SPI                  | 01/26/2010 | 01/26/2010     |

*SERFF Tracking Number:* MCHX-126415671      *State:* Arkansas  
*Filing Company:* Time Insurance Company      *State Tracking Number:* 44308  
*Company Tracking Number:* 8035.POL.AR  
*TOI:* H101 Individual Health - Dental      *Sub-TOI:* H101.000 Health - Dental  
*Product Name:* 8079.POL.XX Individual Dental Indemnity Policy - T  
*Project Name/Number:* 8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company /8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company

Document      McHughConsulting

**Filing Notes**

| <b>Subject</b> | <b>Note Type</b> | <b>Created By</b> | <b>Created On</b> | <b>Date Submitted</b> |
|----------------|------------------|-------------------|-------------------|-----------------------|
| reopened file  | Reviewer Note    | Rosalind Minor    | 01/26/2010        |                       |

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## Disposition

Disposition Date: 01/26/2010

Implementation Date:

Status: Approved-Closed

Comment:

I guess I a little too quick. I had to reopen the filing again to take care of the replaced form.

The form is approved on this date with the remaining file maintaining its original approval date.

| Company Name:             | Overall %<br>Indicated<br>Change: | Overall % Rate<br>Impact: | Written<br>Premium<br>Change for<br>this<br>Program: | # of Policy<br>Holders<br>Affected for this<br>Program: | Written<br>Premium for<br>this Program: | Maximum %<br>Change (where<br>required): | Minimum %<br>Change (where<br>required): |
|---------------------------|-----------------------------------|---------------------------|--|---|---|--|--|
| Time Insurance<br>Company | %                                 | %                         | \$   |   | \$                                      | %  | %  |

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| Schedule                      | Schedule Item                                     | Schedule Item Status | Public Access |
|-------------------------------|---|----------------------|---------------|
| Supporting Document           | Application                                       | Approved-Closed      | Yes           |
| Supporting Document           | Health - Actuarial Justification                  | Approved-Closed      | No            |
| Supporting Document           | Outline of Coverage                               | Approved-Closed      | Yes           |
| Supporting Document (revised) | Revised Form Listing                              | Approved-Closed      | Yes           |
| Supporting Document           | Form Listing                                      | Replaced             | Yes           |
| Supporting Document           | 12.09.09 Submission Letter                        | Approved-Closed      | Yes           |
| Supporting Document           | Authorization Letter                              | Approved-Closed      | Yes           |
| Supporting Document           | Statement of Variability                          | Approved-Closed      | Yes           |
| Supporting Document           | Flesch Certification                              | Approved-Closed      | Yes           |
| Supporting Document           | 12.23.09 Objection Response                       | Approved-Closed      | Yes           |
| Supporting Document           | 8079.BNS.XX - Redlined with revisions             |                      | Yes           |
| Form                          | Dental Policy-Table of Contents                   | Approved-Closed      | Yes           |
| Form                          | Dental Policy-Definitions                         | Approved-Closed      | Yes           |
| Form                          | Dental Policy-Dental Indemnity Insurance Benefits | Approved-Closed      | Yes           |
| Form                          | Dental Policy-Exclusions and Limitations          | Approved-Closed      | Yes           |
| Form                          | Dental Policy-Claim Provisions                    | Approved-Closed      | Yes           |
| Form                          | Dental Policy-Premium Provisions                  | Approved-Closed      | Yes           |
| Form (revised)                | Dental Policy-Effective Date and Termination Date | Approved-Closed      | Yes           |
| Form                          | Dental Policy-Effective Date and Termination Date | Replaced             | Yes           |
| Form                          | Dental Policy-Other Provisions                    | Approved-Closed      | Yes           |
| Form (revised)                | Dental Policy                                     | Approved-Closed      | Yes           |
| Form                          | Dental Policy                                     | Replaced             | Yes           |
| Form (revised)                | Benefit Summary-Dental Insurance                  | Approved-Closed      | Yes           |
| Form                          | Benefit Summary-Dental Insurance                  | Replaced             | Yes           |
| Form                          | Benefit Summary-Dental Insurance                  | Replaced             | Yes           |
| Form                          | Application Form for Dental Insurance             | Approved-Closed      | Yes           |
| Form (revised)                | Outline of Coverage                               | Approved-Closed      | Yes           |
| Form                          | Outline of Coverage                               | Replaced             | Yes           |
| Rate                          | Actuarial Memorandum/Rates                        | Approved-Closed      | No            |

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## Disposition

Disposition Date: 01/26/2010

Implementation Date:

Status: Approved-Closed

Comment:

The filing was reopened in order to update Form 8079-SNS.XX SCH. The form has been reviewed and is approved effective on this date.

The remainder of the filing will maintain the original approval date of 12/28/09.

| Company Name:             | Overall %<br>Indicated<br>Change: | Overall % Rate<br>Impact: | Written<br>Premium<br>Change for<br>this<br>Program: | # of Policy<br>Holders<br>Affected for this<br>Program: | Written<br>Premium for<br>this Program: | Maximum %<br>Change (where<br>required): | Minimum %<br>Change (where<br>required): |
|---------------------------|-----------------------------------|---------------------------|--|---|---|--|--|
| Time Insurance<br>Company | %                                 | %                         | \$   |   | \$                                      | %  | %  |

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| Schedule                      | Schedule Item                                     | Schedule Item Status | Public Access |
|-------------------------------|---|----------------------|---------------|
| Supporting Document           | Application                                       | Approved-Closed      | Yes           |
| Supporting Document           | Health - Actuarial Justification                  | Approved-Closed      | No            |
| Supporting Document           | Outline of Coverage                               | Approved-Closed      | Yes           |
| Supporting Document (revised) | Revised Form Listing                              | Approved-Closed      | Yes           |
| Supporting Document           | Form Listing                                      | Replaced             | Yes           |
| Supporting Document           | 12.09.09 Submission Letter                        | Approved-Closed      | Yes           |
| Supporting Document           | Authorization Letter                              | Approved-Closed      | Yes           |
| Supporting Document           | Statement of Variability                          | Approved-Closed      | Yes           |
| Supporting Document           | Flesch Certification                              | Approved-Closed      | Yes           |
| Supporting Document           | 12.23.09 Objection Response                       | Approved-Closed      | Yes           |
| Supporting Document           | 8079.BNS.XX - Redlined with revisions             |                      | Yes           |
| Form                          | Dental Policy-Table of Contents                   | Approved-Closed      | Yes           |
| Form                          | Dental Policy-Definitions                         | Approved-Closed      | Yes           |
| Form                          | Dental Policy-Dental Indemnity Insurance Benefits | Approved-Closed      | Yes           |
| Form                          | Dental Policy-Exclusions and Limitations          | Approved-Closed      | Yes           |
| Form                          | Dental Policy-Claim Provisions                    | Approved-Closed      | Yes           |
| Form                          | Dental Policy-Premium Provisions                  | Approved-Closed      | Yes           |
| Form (revised)                | Dental Policy-Effective Date and Termination Date | Approved-Closed      | Yes           |
| Form                          | Dental Policy-Effective Date and Termination Date | Replaced             | Yes           |
| Form                          | Dental Policy-Other Provisions                    | Approved-Closed      | Yes           |
| Form (revised)                | Dental Policy                                     | Approved-Closed      | Yes           |
| Form                          | Dental Policy                                     | Replaced             | Yes           |
| Form (revised)                | Benefit Summary-Dental Insurance                  | Approved-Closed      | Yes           |
| Form                          | Benefit Summary-Dental Insurance                  | Replaced             | Yes           |
| Form                          | Benefit Summary-Dental Insurance                  | Replaced             | Yes           |
| Form                          | Application Form for Dental Insurance             | Approved-Closed      | Yes           |
| Form (revised)                | Outline of Coverage                               | Approved-Closed      | Yes           |
| Form                          | Outline of Coverage                               | Replaced             | Yes           |
| Rate                          | Actuarial Memorandum/Rates                        | Approved-Closed      | No            |

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## Disposition

Disposition Date: 12/28/2009

Implementation Date:

Status: Approved-Closed

Comment:

| Company Name:             | Overall %<br>Indicated<br>Change: | Overall % Rate<br>Impact: | Written<br>Premium<br>Change for<br>this<br>Program: | # of Policy<br>Holders<br>Affected for this<br>Program: | Written<br>Premium for<br>this Program: | Maximum %<br>Change (where<br>required): | Minimum %<br>Change (where<br>required): |
|---------------------------|-----------------------------------|---------------------------|--|---|---|--|--|
| Time Insurance<br>Company | %                                 | %                         | \$   |   | \$                                      | %  | %  |

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| Supporting Document           | Form Listing                                      | Replaced             | Yes           |
| Supporting Document           | 12.09.09 Submission Letter                        | Approved-Closed      | Yes           |
| Supporting Document           | Authorization Letter                              | Approved-Closed      | Yes           |
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| Supporting Document           | 12.23.09 Objection Response                       | Approved-Closed      | Yes           |
| Supporting Document           | 8079.BNS.XX - Redlined with revisions             |                      | Yes           |
| Form                          | Dental Policy-Table of Contents                   | Approved-Closed      | Yes           |
| Form                          | Dental Policy-Definitions                         | Approved-Closed      | Yes           |
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| Form                          | Dental Policy-Exclusions and Limitations          | Approved-Closed      | Yes           |
| Form                          | Dental Policy-Claim Provisions                    | Approved-Closed      | Yes           |
| Form                          | Dental Policy-Premium Provisions                  | Approved-Closed      | Yes           |
| Form (revised)                | Dental Policy-Effective Date and Termination Date | Approved-Closed      | Yes           |
| Form                          | Dental Policy-Effective Date and Termination Date | Replaced             | Yes           |
| Form                          | Dental Policy-Other Provisions                    | Approved-Closed      | Yes           |
| Form (revised)                | Dental Policy                                     | Approved-Closed      | Yes           |
| Form                          | Dental Policy                                     | Replaced             | Yes           |
| Form (revised)                | Benefit Summary-Dental Insurance                  | Approved-Closed      | Yes           |
| Form                          | Benefit Summary-Dental Insurance                  | Replaced             | Yes           |
| Form                          | Benefit Summary-Dental Insurance                  | Replaced             | Yes           |
| Form                          | Application Form for Dental Insurance             | Approved-Closed      | Yes           |
| Form (revised)                | Outline of Coverage                               | Approved-Closed      | Yes           |
| Form                          | Outline of Coverage                               | Replaced             | Yes           |
| Rate                          | Actuarial Memorandum/Rates                        | Approved-Closed      | No            |

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Time Insurance Company

## Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 12/15/2009

Submitted Date 12/15/2009

Respond By Date

Dear Jane Neal,

This will acknowledge receipt of the captioned filing.

Objection 1

- Dental Policy, 8079.POL.AR (Form)

Comment:

Coverage for a newborn child is 90 days as outlined under ACA 23-79-129.

Objection 2

- Dental Policy, 8079.POL.AR (Form)

Comment:

There needs to be a provision for the refund of unearned premiums in the event of death of the insured. Refer to ACA 23-79-134.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 12/23/2009  
Submitted Date 12/23/2009

Dear Rosalind Minor,

### Comments:

Please find attached a response to your December 15, 2009, objection letter.

### Response 1

Comments: Please find attached:

#### Related Objection 1

Applies To:

- Dental Policy, 8079.POL.AR (Form)

Comment:

Coverage for a newborn child is 90 days as outlined under ACA 23-79-129.

#### Related Objection 2

Applies To:

- Dental Policy, 8079.POL.AR (Form)

Comment:

There needs to be a provision for the refund of unearned premiums in the event of death of the insured. Refer to ACA 23-79-134.

### Changed Items:

#### Supporting Document Schedule Item Changes

Satisfied -Name: Revised Form Listing

Comment:

Satisfied -Name: 12.23.09 Objection Response

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Comment:

**Form Schedule Item Changes**

| Form Name   | Form Number  | Edition Date | Form Type                             | Action  | Action Specific Data | Readability Score | Attach Document |
|---|--------------|--------------|---------------------------------------|---------|----------------------|-------------------|-----------------|
| Dental Policy-Effective Date and Termination Date | 8079.EFF. AR |              | Matrix                                | Revised |                      | 53.000            |                 |
| <b>Previous Version</b>                           |              |              |                                       |         |                      |                   |                 |
| Dental Policy-Effective Date and Termination Date | 8079.EFF. XX |              | Matrix                                | Initial |                      | 53.000            |                 |
| Dental Policy                                     | 8079.POL. AR |              | Policy/Contract/Fraternal Certificate | Revised |                      | 53.000            | 8079_POL_AR.PDF |
| <b>Previous Version</b>                           |              |              |                                       |         |                      |                   |                 |
| Dental Policy                                     | 8079.POL. AR |              | Policy/Contract/Fraternal Certificate | Initial |                      | 53.000            | 8079_POL_AR.PDF |
| Outline of Coverage                               | 8079.OOC .AR |              | Outline of Coverage                   | Revised |                      | 54.600            | 8079_OOC_AR.PDF |
| <b>Previous Version</b>                           |              |              |                                       |         |                      |                   |                 |
| Outline of Coverage                               | 8079.OOC .XX |              | Outline of Coverage                   | Initial |                      | 54.600            | 8079_OOC_XX.PDF |

No Rate/Rule Schedule items changed.

Thank you for your continued assistance with this filing.

Sincerely,  
 SPI McHughConsulting

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**Amendment Letter**

Submitted Date: 01/26/2010

**Comments:**

Dear Ms. Minor:

I apologize, but in reviewing the resubmitted form in the filing package, I now noticed some of the table items appeared misaligned on page 6. I corrected their alignment with the rest of the table. All other items remain the same as my earlier amendment.

I am sorry for any inconvenience.

Jackie Tootchen  
 McHugh Consulting Resources.

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

| Form Number     | Form Type         | Form Name                                  | Action  | Form Action Other | Previous Filing # | Replaced Form # | Readability Score | Attachments         |
|-----------------|-------------------|--|---------|-------------------|-------------------|-----------------|-------------------|---------------------|
| 8079.BNS.X<br>X | Schedule<br>Pages | Benefit<br>Summary-<br>Dental<br>Insurance | Initial |                   |                   |                 | 53.000            | 8079_BNS_X<br>X.PDF |

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**Amendment Letter**

Submitted Date: 01/26/2010

**Comments:**

Dear Ms. Minor:

Thank you for re-opening this filing. Our client, Time Insurance Company, has made some revisions to ranges on the Benefit Summary form, 8079.BNS.XX. They have expanded the ranges to allow provisions for a better benefit. These were the only changes to the form.

Attached is the form in both clean and redlined versions.

We appreciate your time spent on this amendment to the filing. Please contact our office at 215-230-7960 if you have any questions.

Jackie Tootchen  
 McHugh Consulting Resources, Inc.

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

| Form Number | Form Type      | Form Name                        | Action  | Form Action Other | Previous Filing # | Replaced Form # | Readability Score | Attachments     |
|-------------|----------------|----------------------------------|---------|-------------------|-------------------|-----------------|-------------------|-----------------|
| 8079.BNS.XX | Schedule Pages | Benefit Summary-Dental Insurance | Initial |                   |                   |                 | 53.000            | 8079_BNS_XX.PDF |

**Supporting Document Schedule Item Changes:**

**User Added -Name: 8079.BNS.XX - Redlined with revisions**

Comment:

8079\_BNS\_XX - Redlined with revisions .PDF

*SERFF Tracking Number:* MCHX-126415671                      *State:* Arkansas  
*Filing Company:* Time Insurance Company                      *State Tracking Number:* 44308  
*Company Tracking Number:* 8035.POL.AR  
*TOI:* H101 Individual Health - Dental                      *Sub-TOI:* H101.000 Health - Dental  
*Product Name:* 8079.POL.XX Individual Dental Indemnity Policy - T  
*Project Name/Number:* 8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company /8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company

**Reviewer Note**

**Created By:**

Rosalind Minor on 01/26/2010 08:43 AM

**Subject:**

reopened file

**Comments:**

I spoke with the TPA on 1/26/10 and they should have a response within a couple of days.

SERFF Tracking Number: MCHX-126415671 State: Arkansas  
 Filing Company: Time Insurance Company State Tracking Number: 44308  
 Company Tracking Number: 8035.POL.AR  
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental  
 Product Name: 8079.POL.XX Individual Dental Indemnity Policy - T  
 Project Name/Number: 8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company /8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company

## Form Schedule

### Lead Form Number: 8079.POL.AR

| Schedule Item                 | Form Number | Form Type                   | Form Name   | Action  | Action Specific Data                | Readability | Attachment      |
|-------------------------------|-------------|-----------------------------|---|---------|-------------------------------------|-------------|-----------------|
| Approved-Closed<br>12/28/2009 | 8079.TOC.XX | Matrix                      | Dental Policy-Table of Contents                   | Initial |                                     | 53.000      |                 |
| Approved-Closed<br>12/28/2009 | 8079.DEF.AR | Matrix                      | Dental Policy-Definitions                         | Initial |                                     | 53.000      |                 |
| Approved-Closed<br>12/28/2009 | 8079.DEN.XX | Matrix                      | Dental Policy-Dental Indemnity Insurance Benefits | Initial |                                     | 53.000      |                 |
| Approved-Closed<br>12/28/2009 | 8079.EXC.XX | Matrix                      | Dental Policy-Exclusions and Limitations          | Initial |                                     | 53.000      |                 |
| Approved-Closed<br>12/28/2009 | 8079.CLM.AR | Matrix                      | Dental Policy-Claim Provisions                    | Initial |                                     | 53.000      |                 |
| Approved-Closed<br>12/28/2009 | 8079.PRM.AR | Matrix                      | Dental Policy-Premium Provisions                  | Initial |                                     | 53.000      |                 |
| Approved-Closed<br>12/28/2009 | 8079.EFF.AR | Matrix                      | Dental Policy-Effective Date and Termination Date | Revised | Replaced Form #: Previous Filing #: | 53.000      |                 |
| Approved-Closed<br>12/28/2009 | 8079.OTH.AR | Matrix                      | Dental Policy-Other Provisions                    | Initial |                                     | 53.000      |                 |
| Approved-Closed<br>12/28/2009 | 8079.POL.AR | Policy/Contract/Certificate | Dental Policy                                     | Revised | Replaced Form #: Previous Filing #: | 53.000      | 8079_POL_AR.PDF |
| Approved-Closed               | 8079.BNS.XX | Schedule Pages              | Benefit Summary-Dental Insurance                  | Initial |                                     | 53.000      | 8079_BNS_XX.PDF |

SERFF Tracking Number: MCHX-126415671 State: Arkansas  
 Filing Company: Time Insurance Company State Tracking Number: 44308  
 Company Tracking Number: 8035.POL.AR  
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental  
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 Project Name/Number: 8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company /8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company

01/26/2010

|                      |   |                         |               |
|----------------------|---|-------------------------|---------------|
| Approved- Form       | Application/ Application Form for Initial | 43.000                  | Form 28565    |
| Closed 28565         | Enrollment Dental Insurance               |                         | (10_2009).PDF |
| 12/28/2009 (10/2009) | Form                                      |                         | F             |
| Approved- 8079.OOC.  | Outline of Coverage Revised               | Replaced Form #: 54.600 | 8079_OOC_A    |
| Closed AR            | Coverage                                  | Previous Filing #:      | R.PDF         |
| 12/28/2009           |   |                         |               |

Time Insurance Company  
[501 West Michigan  
Milwaukee, WI 53203]

## DENTAL INDEMNITY INSURANCE POLICY

Limited Benefit Policy – This plan provides benefits for dental treatment only.

The insurance described in this Policy is effective on the date shown in the Policy Schedule only if You are eligible for the insurance, become insured, and remain insured subject to the terms, limits and conditions of this plan. This Policy is evidence of Your coverage. This Policy is issued and delivered in the [State] of Arkansas.

This Policy is issued based on the statements and agreements in the application/enrollment form and during the enrollment process, [any exam that may be required,] any other amendments or supplements and payment of the required premium. This Policy may be changed. If that happens, You will be notified of any such changes.

### RIGHT TO EXAMINE POLICY FOR [10-30] DAYS

If You are not satisfied, return the Policy to Us or Our agent within [10-30] days after You have received it. All premiums will be refunded and Your coverage will be void from the Effective Date.

### IMPORTANT NOTICE CONCERNING STATEMENTS IN YOUR APPLICATION/ENROLLMENT FORM FOR INSURANCE

Please read the copy of the application/enrollment form included with this Policy. We issued this coverage in reliance upon the accuracy and completeness of the information provided in the application/enrollment form and during the enrollment process. [If a material omission or misstatement is made in the application/enrollment form, We have the right to deny any claim, rescind the coverage and/or modify the terms of the coverage or the premium amount.] Carefully check the application/enrollment form and, if any information shown in the application/enrollment form is not correct and complete, write to Us at the address above, within 10 days.

[Secretary's Signature]  
Secretary

[President's Signature]  
President

[This Policy is guaranteed renewable until age [65-75] years. We may change premium for this Policy if We change premiums for all policies within the same class.]

This Policy automatically renews except for as stated in the  
Effective Date and Termination Date section.

Read Your Policy carefully to understand coverage limitations and termination provisions.

## GUIDE TO YOUR COVERAGE

The sections of the Policy appear in the following order:

- I Definitions
- II Dental Indemnity Insurance Benefits
- III Exclusions and Limitations
- IV Claim Provisions
- V Premium Provisions
- VI Effective Date and Termination Date
- VII Other Provisions

## I. Definitions

When reading this Policy, terms with a defined meaning will have the first letter of each word capitalized for easy identification. The capitalized terms used in this plan are defined below. Just because a term is defined does not mean it is covered. Please read the Policy carefully.

### Accident or Accidental

Any event that meets all of the following requirements:

[1.] it causes harm to the physical structure of the body.

[2.] it results from trauma.

[3.] it is the direct cause of a loss, independent of disease, dental infirmity or any other cause.

[4.] it is definite as to time and place.

[5.] it happens involuntarily, or entails unforeseen consequences if it is the result of an intentional act.

### [Basic Dental Services

Only those dental services specifically listed by procedure code on the Policy Schedule as Basic Dental Services.]

### Benefit Waiting Period

The period of time coverage must be in force before a Covered Person is eligible for payment of a particular type of benefit. Any applicable Benefit Waiting Period and its term will be shown on the Policy Schedule. Multiple Benefit Waiting Periods may apply [and run concurrently] under this plan.

### Calendar Year

The period beginning on January 1 of any year and ending on December 31 of the same year.

### Cosmetic Services

A surgery, procedure, injection, medication, or treatment primarily designed to improve appearance, self-esteem or body image and/or to relieve or prevent social, emotional or psychological distress.

### Covered Dependent

A person who meets the definition of a Dependent and is enrolled and eligible to receive benefits under this plan, as shown on the Policy Schedule.

### Covered Person

A person who is enrolled and eligible to receive benefits under this plan, as shown on the Policy Schedule.

### Dentally Necessary and Dental Necessity

Dental Treatment rendered to diagnose or treat a dental condition unless it is a Dental Preventive Services procedure as stated in the Policy Schedule. The Dental Treatment must be essential for the care of the teeth and supporting tissues. We must determine that such care:

- [1.] is appropriate and consistent with the diagnosis and does not exceed in scope, duration or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis and treatment of the dental condition; and
- [2.] is commonly accepted as proper care or treatment of the condition in accordance with United States dental standards and federal government guidelines; and
- [3.] can reasonably be expected to result in or contribute substantially to the improvements of a condition; and
- [4.] is provided [in the most conservative manner or] in the least intensive setting without adversely affecting the condition or the quality of dental care provided.

The fact that a Dental Hygienist, Dentist, or other dental care provider, facility or supplier may prescribe, order, recommend or approve a Dental Treatment does not, of itself, make the Dental Treatment Dentally Necessary for the purpose of determining eligibility under this Policy.

#### Dentist

A person licensed to practice dentistry by the state, or other geographic area [within the United States and its territories,] in which the covered procedure is rendered. The Dentist must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed.

#### Dental Hygienist

A person licensed as dental hygienist by the state, or other geographic area [within the United States and its territories,] in which the covered procedure is rendered. The Dental Hygienist must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed.

#### [Dental Preventive Services

Only those Dental Preventive Services specifically listed by procedure code on the Policy Schedule as Dental Preventive Services.]

#### Dependent

A Dependent is:

- [1.] the Policyholder's lawful spouse[, including the Policyholder's Domestic Partner if recognized under applicable law]; or
- [2.] the Policyholder's naturally born child, legally adopted child, a child that is placed for adoption with the Policyholder, a stepchild or a child for whom the Policyholder is the legal guardian:
  - [a.] [who is unmarried; and]
  - [b.] [who is age [18] or younger; and]
  - [c.] [who is claimed as an exemption on Your most recent federal income tax return, except for a Dependent child who is a full-time student.]

If Your unmarried child is age [19] or older, the child will be considered a Dependent if You give Us proof that:

- [1.] [the child is a full-time student at an accredited educational institution, college or university. A student will be considered full-time if the student meets the standards for full-time status at the school the student is attending. A student will be considered full-time during regular vacation periods that interrupt, but do not terminate, the continuous full-time course of study; or]
- [2.] [the child is not capable of self-sustaining employment or engaging in the normal and customary activities of a person of the same age because of mental incapacity or physical handicap. The child must also be chiefly dependent on the Policyholder for financial support and be claimed as an exemption on Your most recent federal income tax return. ]

A child will no longer be a Dependent on the earliest of the date that he or she:

- [1.] [is no longer a full-time student; or]
- [2.] [ceases to be claimed as an exemption on the Policyholder's federal income tax return, except for a Dependent child who is a full-time student; or]
- [3.] [attains age [24]; or]
- [4.] [marries; or]
- [5.] [is over age [18] and is capable of self-sustaining employment because he or she is no longer mentally incapacitated or physically handicapped.]

[If only Dependent children are covered under this plan, the youngest child will be considered the Policyholder. All siblings of the Policyholder will be considered Covered Dependents if they meet the requirements above.]

#### [Domestic Partner

A person of the same or opposite gender who resides with the Policyholder in a long-term relationship of indefinite duration. The partners have an exclusive mutual commitment to be jointly responsible for each others common welfare and share financial obligations. The Domestic Partner must meet all of the following requirements:

- [1.] be at least [18] years of age.
- [2.] be competent to enter into a contract.
- [3.] not be related by blood to a degree of closeness that would prohibit legal marriage in the state in which he or she legally resides.

A Domestic Partner must provide Us with [an affidavit attesting that the domestic partnership has existed for a minimum period of [24 months]] [evidence of state registry or license of the civil union/partnership] at the time of enrollment under this plan. [Proof that the Domestic Partner relationship continues to exist will be requested by Us periodically.]

#### Effective Date

The date coverage under this plan begins for a Covered Person as stated on the Policy Schedule. The Covered Person's coverage begins at 12:01 a.m. local time in the state of issuance on the Effective Date approved by Us.

#### Emergency Dental Treatment

Any Dentally Necessary service, procedure, or supply which is rendered as the direct result of unforeseen events or circumstances which require prompt attention.

[Experimental or Investigational Services Treatment, services, supplies or equipment which, at the time the treatment is rendered, We determine are:

- [1.] not proven to be of benefit for diagnosis or treatment of the dental condition; or
- [2.] not generally used or recognized by the medical or dental community as safe, effective and appropriate for diagnosis or treatment; or
- [3.] in the research or investigational stage, provided or performed in a special setting for research purposes or under a controlled environment or clinical protocol; or
- [4.] obsolete or ineffective for the treatment; or
- [5.] medications used for non-FDA approved indications and/or dosage regimens.]

#### Family Plan

A plan of insurance covering the Policyholder and one or more of the Policyholder's dependents as shown on the Policy Schedule.

#### Functioning Natural Tooth (Teeth)

A healthy tooth with normal function in the mastication process in the upper or lower arch and that is opposed in the other arch by another tooth or prosthetic replacement. For purposes of this Policy, third molars are not considered Functioning Natural Teeth.

#### Home Office

Our office in [Milwaukee, Wisconsin] or other administrative offices as indicated by Us.

#### Immediate Family Member

An Immediate Family Member is:

- [1.] You or Your spouse; or
- [2.] the children, brothers, sisters and parents of either You or Your spouse; or
- [3.] the spouses of the children, brothers and sisters of You and Your spouse; or
- [4.] anyone with whom a Policyholder has a relationship based on a legal guardianship.

#### Injury

Accidental bodily damage, independent of all other causes, occurring unexpectedly and unintentionally.

[Major Dental Services

Only those dental services specifically listed by procedure code on the Policy Schedule as Major Dental Services.]

[Orthodontic Dental Services

Only those orthodontic services specifically listed by procedure code on the Policy Schedule as Orthodontic Dental Services.]

[Orthodontic Treatment

The corrective movement of teeth through the bone by means of an active appliance to correct a handicapping Malocclusion (a Malocclusion severely interfering with a person's ability to chew food) of the mouth by use of Orthodontic Dental Services. [We will make the determination of the severity of the Malocclusion.]]

Policy

The contract issued by Us to the Policyholder for benefit of Covered Persons.

Policyholder

The person listed on the Policy Schedule as the Policyholder.

[Policy Year

The period beginning on the month and day of the Effective Date in any year and ending on the same month and day as the Effective Date in the following year.]

Sickness

A disease or illness of a Covered Person. Sickness does not include a family history of a disease or illness or a genetic predisposition for the development of a future disease or illness.

Single Plan

A plan of insurance covering only the Policyholder as shown in the Policy Schedule.

We, Us, Our, Our Company

Time Insurance Company or its administrator.

You, Your, Yours

The person listed on the Policy Schedule as the Policyholder.

## II. Dental Indemnity Insurance Benefits

WE WILL PAY BENEFITS ONLY FOR THE SERVICES AND SUPPLIES LISTED AS DENTAL BENEFITS IN THIS SECTION OF THE PLAN. HOW BENEFITS ARE PAID AND THE MAXIMUM BENEFIT FOR THE COVERED SERVICES AND SUPPLIES LISTED IN THIS SECTION ARE SHOWN IN THE POLICY SCHEDULE.

REFER TO THE EXCLUSIONS SECTION FOR SERVICES AND SUPPLIES THAT ARE NOT COVERED UNDER THIS POLICY.

[Benefits paid under this section are subject to any maximum benefit limitation provided under this plan. Benefits are subject to all the terms, limits and conditions in this plan.]

[We will not pay benefits for Dental Treatment rendered during a Covered Person's Benefit Waiting Period. A Benefit Waiting Period only applies if it is shown in the Policy Schedule. [Benefits are available from the first day Covered Charges are incurred for a Dental Injury that is sustained on or after the Covered Person's Effective Date.]]

We pay only for Dental Treatment, according to the following classifications and subject to the benefit amounts provided on the Policy Schedule, when Dentally Necessary and provided by a Dentist or Dental Hygienist licensed to perform such procedure or treatment:

### [Dental Preventive Benefits

We will pay the benefit shown on the Policy Schedule for Dental Preventive Services. All preventive visits must be separated by at least [90-270] calendar days for benefits to be payable. The benefit amount is paid only once regardless of the number of Dental Preventive Services provided during any one visit. [To be eligible for benefits, Dental Preventive Services must be rendered by a licensed Dentist or Dental Hygienist.]]

### [Basic Dental Services Benefits

We will pay the Scheduled Benefit for Basic Dental Services as show on the Policy Schedule. [The Scheduled Benefit will be reduced by [5-100]% for all Basic Dental Services rendered during the first [[180-365] calendar days] [1-2] [Policy Year][s] following the Effective Date of coverage. Thereafter the full Scheduled Benefit will be paid for covered Basic Dental Services.] [All benefits for Basic Dental Services rendered during the same Calendar Year are subject to the maximum Calendar Year benefit for Basic Dental Services shown on the Policy Schedule.] [All benefits for covered Basic Dental Services are subject to the Basic and Major Services Combined Maximum Benefit Limitation shown on the Policy Schedule.]]

### [Major Dental Services Benefits

We will pay the Scheduled Benefit for Major Dental Services as show on the Policy Schedule. [The Scheduled Benefit will be reduced by [5-100]% for all Major Dental Services rendered during the first [[180-365] calendar days] [1-3][Policy Year][s] following the Effective Date of coverage. [The Scheduled Benefit will be reduced by [5-100]% for all Major Dental Services rendered during the second [[180-365] calendar days] [1-3] [Policy Year][s] following the Effective Date of coverage.] Thereafter the full Scheduled Benefit will be paid for covered Major Dental Services.] [All benefits for Major Dental Services rendered during the same Calendar Year are subject to the maximum Calendar Year benefit for Major Dental Services shown on the Policy Schedule.] [All benefits for covered Major Dental Services are subject to the Basic and Major Services Combined Maximum Benefit Limitation shown on the Policy Schedule.]]

[Temporomandibular Joint Services Benefits

We will pay the Scheduled Benefit for Temporomandibular Joint Services as show on the Policy Schedule. [A Benefit Waiting Period of [[180-365] calendar days] [1-3] [Policy Year][s] applies for each Covered Person.] [The Scheduled Benefit will be reduced by [5-100]% for all Temporomandibular Joint Services rendered during the first [1-3] [Policy Year][s] following the [Effective Date of coverage][end of the Benefit Waiting Period].] [Thereafter the full Scheduled Benefit will be paid for covered Temporomandibular Joint Services.] [All benefits for Temporomandibular Joint Services rendered during the same Calendar Year are subject to the maximum Calendar Year benefit for Temporomandibular Joint Services shown on the Policy Schedule.] [All benefits for Temporomandibular Joint Services are subject to the maximum lifetime benefit for Temporomandibular Joint Services shown on the Policy Schedule, per Covered Person.]]

[Orthodontic Benefits

[Orthodontic Benefits are payable only after satisfaction of the Orthodontic Dental Services Benefit Waiting Period. The Orthodontic Dental Services Benefit Waiting Period is [1-3] Policy Year[s] following the Effective Date of coverage.]

[Only Covered Persons who are under age [18] years are eligible for Orthodontic Benefits. Orthodontic Treatment must have been initiated prior to the Covered Person's [17<sup>th</sup>] birthday. Benefits for Orthodontic Treatment cease upon attainment of the Covered Person's [18<sup>th</sup>] birthday.]

Benefits for Orthodontic Treatment are not payable for expenses incurred for retention of orthodontic relationships. Benefits for Orthodontic Treatment are payable only for active Orthodontic Treatment for the Orthodontic Dental Services listed on the Policy Schedule.

[We will pay benefits for Orthodontic Treatment involving Orthodontic Dental Services listed on the Policy Schedule when the treatment begins while the Covered Person is insured under the plan. No payment will be made for the Orthodontic Treatment if the appliances or bands are inserted prior to becoming insured. We consider Orthodontic Treatment to be started on the date the bands or appliances are inserted. Any other Orthodontic Treatment that can be completed on the same day it is rendered is considered to be started and completed on the date the Orthodontic Treatment is rendered.]

We will pay the benefit amount shown in the Policy Schedule after any required Benefit Waiting Period has been satisfied. The maximum benefit payable to a Covered Person is shown in the Policy Schedule. The maximum benefit will apply even if coverage is interrupted.

[We will make a payment for covered orthodontic services related to the initial Orthodontic Treatment, which consists of diagnosis, evaluation, pre-care and insertion of bands or appliances. After the payment for the initial Orthodontic Treatment, benefits for covered Orthodontic Dental Services will be paid in equal [monthly] [quarterly] payments over the course of the remaining Orthodontic Treatment. The initial Orthodontic Treatment and [quarterly] [monthly] indemnity benefit amounts are shown on the Policy Schedule.]]

### III. Exclusions and Limitations

#### Limited Benefits

This Policy pays limited, fixed indemnity benefits for Dental Treatments only. See the Policy Schedule for the limited benefit amounts and maximum benefit limitations.

#### Exclusions

[We will not pay benefits for any of the following:

- [1.] [any procedure or treatment not shown on the Policy Schedule.]
- [2.] [any procedure rendered during an applicable Benefit Waiting Period.]
- [3.] [any amount in excess of a Calendar Year or Lifetime maximum benefit limitation.]
- [4.] [Dental Preventive Benefits when there is less than [90-270] calendar days between the dates of service for Dental Preventive Services.]
- [5.] [all Experimental or Investigative Services.]
- [6.] [any procedure performed by a person other than a Dentist or Dental Hygienist.]
- [7.] [any procedure performed by a Covered Person's Immediate Family Member.]
- [8.] [all services that are not Dentally Necessary.]
- [9.] [repairs to dental work less than [30-180] calendar days following completion of the initial procedure.]
- [10.] [prosthetics replaced less than [2-20] years following the previous placement.]
- [11.] [crowns replaced less than [2-20] years following the previous placement.]
- [12.] [inlays or onlays replaced less than [2-20] years following the last placement.]
- [13.] [dental implants or the removal of implants.]
- [14.] [Cosmetic Services, unless performed to correct a functional disorder.]
- [15.] [services performed outside the United States [and][,] [its territories] [and Canada] except for services that are received for Emergency Dental Treatment.]
- [16.] [replacement of any tooth missing prior to the Effective Date.]
- [17.] [placement of full or partial dentures, whether removable or fixed, including a Maryland Bridge, unless replacing a Functioning Natural Tooth extracted after the Effective Date[and not within a Benefit Waiting Period].]

- [18.] [for Covered Persons under age 16, inlays, onlays, bridgework or crowns except for stainless steel or plastic crowns.]
- [19.] [any charge or procedure for treatment required because of Dental Injury or disease due to:
- [a.] [war or any act of war, whether declared or undeclared.]
  - [b.] [participation in the military service of any country or international organization[,including non-military units supporting such forces.]]
  - [c.] [charges for Sickness or Injury caused or aggravated by attempted suicide or self-inflicted Sickness or Injury, even if the Covered Person did not intend to cause the harm which resulted from the action which led to the self-inflicted Sickness or Injury.]
  - [d.] [taking part in a riot or insurrection, or an act of riot or insurrection.]
  - [e.] [participating in, voluntarily attempting to commit or commission of a felony, whether or not charged, or engaging in an illegal occupation or activity at the time of an Accident.]
  - [f.] [voluntary use of any controlled substance, as defined by statute, except when administered in accordance with the advice of the Covered Person's health care practitioner.]
  - [g.] [riding in any aircraft not licensed to carry passengers or not operated by a duly licensed pilot.]
  - [h.] [charges for treatment or services required due to an Injury sustained in operating a motor vehicle while the Covered Person's blood alcohol level, as defined by law, was [.08] or higher. This exclusion applies whether or not the Covered Person is charged with any violation in connection with the Accident.]
- [20.] [procedures rendered before the Effective Date or after the termination date of coverage.]
- [21.] [orthodontic treatment and services]

[In addition to the Exclusions listed above, the following exclusion applies to Orthodontic Dental Services coverage:

We will not pay benefits for Orthodontic Treatment procedures rendered after the Covered Person's [18<sup>th</sup> birthday.]

## IV. Claim Provisions

### Proof of Loss

Most providers will file claims directly with Us. You are responsible for filing a claim with Us if the provider does not file it. The following provisions tell You how to file claims with Us.

We must receive written or electronic notice of the services that were received for which the claim is made. Notice must be provided to Us within [90 days] after a covered loss occurs or as soon as reasonably possible. Unless You are declared incompetent by a court of law, written or electronic proof of loss must be sent to Us within [12-15 months] of the date of loss.

The proof of loss must include all of the following:

- [1.] Your name and Policy number.
- [2.] the name of the Covered Person who incurred the claim.
- [3.] the name[, national provider identifier (NPI)] and address of the provider of the services.
- [4.] an itemized bill from the provider of the services that includes the Dental Treatment performed in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature or by narrative description.

When We receive written or electronic proof of loss, We may require additional information. You must furnish all items We decide are necessary to determine Our liability in accordance with the Right to Collect Information provision in this section. We will not pay benefits if the required information or authorization for its release is not furnished to Us. We reserve the right to request X-rays, narratives and other diagnostic information, as We see fit, to determine benefits.

### Right to Collect Information

To determine Our liability, We may request additional information from a Covered Person, Dentist, Dental Hygienist, facility, or other individual or entity. A Covered Person must cooperate with Us, and assist Us by obtaining the following information within [30-90 days] of Our request. Charges will be denied if We are unable to determine Our liability because a Covered Person, Dentist, Dental Hygienist, facility, or other individual or entity failed to:

- [1.] authorize the release of all medical and dental records to Us and other information We requested.
- [2.] provide Us with information We requested about pending claims.
- [3.] provide Us with information that is accurate and complete.
- [4.] have any examination completed as requested by Us.
- [5.] provide reasonable cooperation to any requests made by Us.

Such charges may be considered for benefits upon receipt of the requested information, provided all necessary information is received prior to expiration of the time allowed for submission of claim information as set forth in this Claim Provisions section.

#### Physical Examination

We have the right to have a provider of Our choice examine a Covered Person at any time regarding a claim for benefits. These exams will be paid by Us.

#### Payment of Benefits

Benefits will be paid when We receive due written or electronic proof of loss, subject to any time period requirements under state law. Benefits for services provided will be paid to the Policyholder unless they have been assigned to a provider. Any benefits unpaid at Your death will be paid at Our option to Your spouse, [Your Domestic Partner,] Your estate or the providers of the services.

We will pay dental claims when coded according to the [American Dental Association Uniform Code on Dental Procedures and Nomenclature] [or] [Current Dental Terminology (CDT) manual]. We will not pay for: charges that are billed separately as professional services when the procedure requires only a technical component; or charges that are billed incorrectly or billed separately but are an integral part of another billed service, as determined by Us; or other claims that are improperly billed; or duplicates of previously received or processed claims.

Any amount We pay in good faith will release Us from further liability for that amount. Payment by Us does not constitute any assumption of liability for further coverage under this plan.

#### Overpayment

If a benefit is paid under this plan and it is later shown that a lesser amount should have been paid, We will be entitled to recover the excess amount from You or the person or entity receiving the incorrect payment. [We may offset any overpayment to You or a provider against future benefit payments.]

#### Rights of Administration

We maintain Our ability to determine Our rights and obligations under this plan including, without limitation, the eligibility for and amount of any benefits payable.

#### Claims Involving Misrepresentation or Fraud

Claims will be denied in whole or in part in the event of misrepresentation or fraud by a Covered Person or a Covered Person's representative. If benefits are paid under this plan and it is later shown the claims for these benefits involved misrepresentation or fraud, We will be entitled to a refund from You or the person or entity receiving the payment.

A claim will not be honored if the Covered Person or the provider of the charges will not, or cannot, provide adequate documentation to substantiate that treatment was rendered for the claim submitted. If the Covered Person, or anyone acting on the Covered Person's behalf, knowingly files a fraudulent claim, claims may be denied in whole or in part, coverage may be terminated or rescinded, and the Covered Person may be subject to civil and/or criminal penalties.

#### Workers' Compensation Not Affected

Insurance under this plan does not replace or affect any requirements for coverage by workers' compensation insurance. If state law allows, We may participate in a workers' compensation dispute arising from a claim for which We paid benefits.

#### Claim Appeal

You have the right to request a review of all adverse claim decisions. A review must be requested in writing within [180-365 days] following Your receipt of the notice that the claim was denied or reduced.

## V. Premium Provisions

### Consideration

This plan is issued based on the statements and agreements in the Covered Person's application/enrollment form and during the enrollment process, any exam of a Covered Person that is required, any other amendments or supplements to the application/enrollment form and payment of the required premium. Each renewal premium is payable on the due date subject to the Grace Period provision in this section.

### Premium Payment

The initial premium must be paid on or before the due date for this coverage to be in force. Subsequent premiums are due as billed by Us. Each renewal premium must be received by Us on its due date subject to the Grace Period provision in this section. Premiums must be received in cash or check at Our office on the date due. [We may agree to accept premium payment in alternative forms, such as credit card [or automatic charge to a bank account].] [We reserve the right to dishonor any such agreement for payment of premium during the grace period if We tried to obtain payment for the amount due using the alternative method but were unsuccessful.]

Your premium may be adjusted from time to time based on different factors including, but not limited to, Your geographic area, [gender,] [age,] payment method and plan design. All premium adjustments will be made to individuals on the basis of shared characteristics. The premium may also change if You add or delete Covered Dependents, change the payment method, move to another zip code or otherwise change the coverage. [The mode of payment (monthly, quarterly or other) is subject to change. You will be notified at least 60 days in advance of any such change.]

### Grace Period

There is a grace period of [31 days] for the payment of each premium due after the initial premium. If the full premium due is not received at Our Home Office by the end of the grace period, the coverage will end on the date that the grace period ends. [If any claims become payable during the grace period, any unpaid premium due will be deducted from the claim payment.] If the premium is received during or by the end of the grace period, coverage will continue without interruption unless You call Our office or give Us written notice to cancel the coverage.

### [Reinstatement

If any premium is not paid within the required time period, coverage for You and any Covered Dependents will lapse. The coverage will be reinstated only if all of the following requirements are met:

- [1.] the lapse was not more than [30-180] days.
- [2.] You submit an application/enrollment form for reinstatement to Us along with the required premium payment. Submission of premium to Your agent is not submission of premium to Us. [We may require payment of unpaid premium during the lapsed period, but not to any period prior to the date occurring 60 days before the reinstatement date].
- [3.] We approve Your application/enrollment form for reinstatement.

The coverage will be reinstated on the date We approve Your application/enrollment form for reinstatement. If We have not responded to Your application/enrollment form for reinstatement by the 45th day after We receive the application/enrollment form, the coverage will be reinstated on that date. If the

coverage is reinstated, the loss resulting from an Injury will only be covered only if the Injury is sustained on or after the date of reinstatement. Benefits under the Policy will not be paid for dental Sickness or conditions diagnosed between the lapse date and the tenth day following the date of reinstatement.

In all other respects, You and Our Company will have the same rights as existed under this plan before the coverage lapsed, subject to any provisions included with or attached to this plan in connection with the reinstatement.]

[Covered Dependent Conversion

A Covered Dependent may be eligible to convert to another similar dental plan that We issue in the Covered Dependent's state of residence at the time coverage terminates under this plan if:

- [1.] the Covered Dependent's insurance terminates due to a valid decree of divorce between the Policyholder and the Covered Dependent; or
- [2.] the Covered Dependent's insurance terminates due to the death of the Policyholder; or
- [3.] a Covered Dependent child's insurance terminates because the child no longer meets the eligibility requirements for a Dependent.

To obtain conversion coverage, the Covered Dependent must submit a written application/enrollment form and the required premium to Us within [31 days] after coverage under this plan terminates. Evidence of insurability will not be required. Coverage will be provided on the dental insurance form that We offer for providing conversion coverage at that time. However, the conversion plan may provide different benefit levels, covered services and premium rates.

If written enrollment is not made within [31-60 days] following the termination of insurance under this plan, conversion coverage may not be available.

The conversion coverage will take effect at 12:01 a.m. local time at the covered person's residence on the day after coverage under this plan terminates. Benefits paid under the new plan cannot exceed any applicable maximum benefit that would have otherwise been paid under the terms of this Policy if coverage under this Policy would have remained in force.]

## VI. Effective Date and Termination Date

### Eligibility and Effective Date of Policyholder

A person who is eligible may elect to be covered under this plan by completing the enrollment process and submitting any required premium. [You must be a resident of the state where this plan is issued.] [Evidence of insurability must also be provided.] Your coverage will take effect at 12:01 a.m. local time in the state of issuance on the Effective Date approved by Us.

[If the Policyholder moves to a different state after the Effective Date, We will replace this Policy with a similar plan that is issued in the Policyholder's new state of residence. Coverage under the new plan will be effective on the date the Policyholder becomes a resident of the new state. If the Policyholder moves to a state where We do not provide insurance coverage under a plan similar to this Policy, We reserve the right to terminate this coverage for You and any Covered Dependents.]

### Eligibility and Effective Date of Dependents

The following information explains how You can obtain coverage for any Dependents that You want to add to Your plan. [If the Policyholder has a Single Plan on the Effective Date of his or her plan, a Dependent cannot be added after the Policyholder's Effective Date.] [If this is a Family Plan, a] [A] Dependent can be added after the Policyholder's Effective Date. To be covered under this plan, a person must meet the Dependent definition in this plan and is subject to the additional requirements below:

- [1.] Adding a Newborn Child: You must call Our office or send Us written notice of the birth of the child and We must receive any required additional premium within 90 days of birth or the next premium due date, whichever is later. The Effective Date of coverage will be 12:01 a.m. local time at the Policyholder's state of residence on the date the child is born. [If this is a Single Plan and these requirements are not met, the child will not be covered from birth. However, if this is a Family Plan and if][If] these requirements are not met, Your newborn child will be covered only for the first 31 days from birth.
- [2.] Adding an Adopted Child or Child Placed for Adoption: A newly adopted child can be added on the date the child is placed with the Policyholder in anticipation of legal adoption and the Policyholder assumes a legal obligation for support of the child. You must call Our office or send Us written notice of the placement for adoption of the child and We must receive any required additional premium within 60 days of the placement for adoption. The Effective Date of coverage will be 12:01 a.m. local time at the Policyholder's state of residence on the date the child is placed for adoption. [If this is a Single Plan and these requirements are not met, the child will not be covered from date of placement. However, if this is a Family Plan and if][If] these requirements are not met, Your newly adopted child will be covered for only for the first 31 days from the earlier of adoption or placement for adoption. A child is no longer considered adopted if, prior to legal adoption, You relinquish legal obligation for support of the child and the child is removed from placement.
- [3.] Adding Any Other Dependent: To add any other Dependent, an application/enrollment form must be completed and sent to Us along with any required premium. Evidence of insurability must also be provided. The Effective Date of coverage will be 12:01 a.m. local time in the state of issuance on the Effective Date approved by Us.

### Termination Date of Coverage

The Policyholder may cancel this coverage at any time by sending Us written notice or calling Our office. Upon cancellation, We will return the unearned portion of any premium paid, in accordance with the laws in the Policyholder's state of residence. In the event of the Policyholder's death, We will refund within (30) thirty days after notice to Us, the unearned portion of any premium paid.

This coverage will terminate at 12:01 a.m. local time at the Policyholder's state of residence on the earliest of the following dates:

- [1.] the date We receive a request in writing or by telephone to terminate this plan or on a later date that is requested by the Policyholder for termination.
- [2.] the date We receive a request in writing or by telephone to terminate coverage for a Covered Dependent or on a later date that is requested by the Policyholder for termination of a Covered Dependent.
- [3.] the date this plan lapses for nonpayment of premium per the Grace Period provision in the Premium Provisions section.
- [4.] [the date there is fraud or material misrepresentation made by or with the knowledge of any Covered Person [applying for this coverage or] filing a claim for benefits.]
- [5.] [the date all policies with the same form number as this Policy are non-renewed in the state in which this Policy was issued or the state in which the Policyholder presently resides.]
- [6.] [the date We terminate or non-renew [health][dental] insurance coverage in the individual market in the state in which this Policy was issued or the state in which You presently reside. We will give You advance notice, as required by state law, of the termination of Your coverage.]
- [7.] [[on][t]he date the Policyholder moves to a state where We do not provide insurance coverage under the same plan as this Policy[, We reserve the right to terminate this coverage].]
- [8.] [for a Covered Dependent: on the date a Covered Dependent no longer meets the Dependent definition in this plan.]
- [9.] [the date the Policyholder attains age [65-75] years.] [The anniversary date of this Policy following the Policyholder's [65<sup>th</sup> – 75<sup>th</sup>] birthday.]

## VII. Other Provisions

### Assignment [Prohibited]

A Covered Person's right to benefits under this Policy is [not] assignable. [A signed copy of the assignment must be sent to Our Home Office in a form acceptable to Us. The assignment is subject to any payment made or other action taken before We receive the assignment.]

### Modification of Policy or Coverage

The Policy may be changed at any time. We will give You [30-90] days notice prior to any change. No change in the Policy will be valid unless approved by one of Our executive officers and included with this Policy. No agent or other employee of Our Company has authority to waive or change any plan provision or waive any other applicable enrollment or application requirements.

We may modify the insurance coverage for You and any Covered Dependents. This modification will be consistent with state law and will apply uniformly to all policies in the state of issue with Your plan of coverage. You will be notified of any change.

### Clerical Error

If a clerical error is made by Us, it will not affect the insurance to which a Covered Person is entitled. Delay or failure to report termination of any insurance will not continue the insurance in force beyond the date it would have terminated according to this Policy. The premium charges will be adjusted as required, but not for more than [two years] prior to the date the error was found. If the premium was overpaid, We will refund the difference. If the premium was underpaid, the difference must be paid to Us within [60-180 days] of Our notifying You of the error.

### Conformity with State Statutes

If this plan, on its Effective Date, is in conflict with any applicable federal laws or laws of the state where it is issued, it is changed to meet the minimum requirements of those laws. In the event that new or applicable state or federal laws are enacted which conflict with current provisions of this plan, the provisions that are affected will be administered in accordance with the new applicable laws, despite anything in the plan to the contrary.

### Enforcement of Plan Provisions

Failure by Us to enforce or require compliance with any provision within this plan will not waive, modify or render any provision unenforceable at any other time, whether the circumstances are the same or not.

### Entire Contract

This Policy is issued to the Policyholder. The entire contract of insurance includes the Policy, a Covered Person's application/enrollment form, and any riders and endorsements. A copy of the application/enrollment form shall be included when the Policy is issued.

### Representations

In the absence of fraud, all statements made on the application/enrollment form will be deemed representations and not warranties. This provision does not preclude defenses based upon provisions relating to eligibility. No statement made in the application/enrollment form will be used in any suit or action at law or equity unless a copy of the application/enrollment form is furnished to the Policyholder, or

in the event of death or incapacity of the Policyholder, a copy will be furnished to the Policyholder's beneficiary or personal representative.

#### [Incentives, Rebates and Contributions

[We may elect to furnish [or participate in programs with other organizations that furnish] [group applicants for coverage] [members of groups applying for coverage][individual applicants for coverage][Covered Persons] [individuals] [that meet common criteria or requirements determined by Us] [not to include health, dental or claims history] with "premium holidays" or programs where premiums, fees, plan benefit limits will be discounted, credited, refunded, waived or otherwise adjusted [or] [where other gifts or items of value may be offered or provided to You at no charge or a discount] [at a time or times] [or] [for a period] determined by Us.]]

#### Misstatements

If a Covered Person's material information has been misstated and the premium amount would have been different had the correct information been disclosed, an adjustment in premiums may be made based on the corrected information. In addition to adjusting future premiums, We may require payment of past premiums at the adjusted rate to continue coverage. If the Covered Person's age is misstated and coverage would not have been issued based on the Covered Person's true age, Our sole liability will be to refund all of the premiums paid for that Covered Person's coverage, minus the amount of any benefits paid by Us.

#### Incontestability and Time Limit on Certain Defenses

Within the first three years after the Effective Date of coverage, We have the right to rescind or modify Your Policy of insurance coverage and/or deny a claim for a Covered Person if the application/enrollment form contains an omission or misrepresentation, whether intended or not, which We determine to be material. We also reserve the right to rescind a Policy of insurance and/or deny a claim for a fraudulent misstatement or omission at any time during the coverage period.

#### Legal Action and Forum

No suit or action at law or in equity may be brought to recover benefits under this plan until expiration of 60 days after Proof of Loss has been furnished in accordance with the requirements of this Policy. No suit or action at law or in equity can be brought later than 3 years from the date loss is incurred. Any lawsuits or disputes arising under the terms of the Policy must be brought in the United States District Court for the Eastern District of Wisconsin.



|         |  |
|---------|--|
| [00471] | [Diagnostic photographs]   |
| [00501] | [Histopathologic Examinations]   |
| [09310] | [Consultation (diagnostic service provided by Dentist or physician other than practitioner)] |
| [01110] | [Prophylaxis – adult]  |
| [01120] | [Prophylaxis – child]  |
| [01201] | [Topical application of fluoride (including prophylaxis) – child]                            |
| [01203] | [Topical application of fluoride (prophylaxis not included) – child]                         |
| [01204] | [Topical application of fluoride (prophylaxis not included) – adult]                         |
| [01205] | [Topical application of fluoride (including prophylaxis) – adult]                            |
| [01351] | [Sealant – per tooth]  |
| [01510] | [Space maintainer – fixed – unilateral]  |
| [01515] | [Space maintainer - fixed – bilateral]   |
| [01520] | [Space maintainer - removable – unilateral]  |
| [01525] | [Space maintainer - removable – bilateral]   |
| [01550] | [Re-cementation of space maintainer]]]   |

| <b>[Basic Dental Services Benefits:</b>   |  |                          |
|---|--|--------------------------|
| [Benefits for all covered Basic Dental Services rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [\$100-50,000] [per Covered Person.]]                      |  |                          |
| [All benefits for covered Basic Dental Services are subject to the Basic and Major Services Combined Maximum Benefit Limitation shown on this Policy Schedule.]                                     |  |                          |
| [The Scheduled Benefits shown below will be reduced by [5-100]% for any covered procedure rendered during the first [[180-365] calendar days] [[1-2] Policy Year[s]] following the Effective Date.] |  |                          |
| <b>Procedure Code</b>   | <b>Basic Dental Services</b>   | <b>Scheduled Benefit</b> |
| [09110]   | [Palliative (emergency) treatment of dental pain – minor procedure]                  | [\$15-100]               |
| [09220]   | [Deep sedation/general anesthesia – first 30 minutes]                                | [\$50-300]               |
| [09221]   | [Deep sedation/general anesthesia-each additional 15 minutes]                        | [\$25-150]               |
| [02140]   | [Amalgam – one surface, primary or permanent]  | [\$35-150]               |
| [02150]   | [Amalgam – two surfaces – primary or permanent]                                      | [\$40-150]               |
| [02160]   | [Amalgam – three surfaces – primary or permanent]                                    | [\$40-150]               |
| [02161]   | [Amalgam – four or more surfaces, primary or permanent]                              | [\$45-200]               |
| [02330]   | [Resin-based composite – one surface, anterior]                                      | [\$30-150]               |
| [02331]   | [Resin-based composite – two surface, anterior]                                      | [\$35-150]               |
| [02332]   | [Resin-based composite – three surfaces, anterior]                                   | [\$40-200]               |
| [02335]   | [Resin-based composite – four or more surfaces or involving incisal angle(anterior)] | [\$45-200]               |
| [02336]   | [Resin-based composite crown (anterior-primary)]                                     | [\$45-200]               |
| [02391]   | [Resin-based composite – one surface, posterior – permanent or primary]              | [\$25-150]               |
| [02392]   | [Resin-based composite – two surfaces, posterior – permanent or primary]             | [\$30-150]               |
| [02393]   | [Resin-based composite – three surfaces, posterior – permanent or primary]           | [\$35-200]               |
| [02394]   | [Resin-based composite – four or more surfaces, posterior]                           | [\$45-250]               |
| [02410]   | [Gold foil – one surface]  | [\$80-300]               |
| [02420]   | [Gold foil – two surfaces]   | [\$100-400]              |
| [07111]   | [Coronal re-cement – deciduous tooth]  | [\$15-100]               |
| [07140]   | [Extraction, erupted tooth or exposed root (elevation and/or forceps removal)]       | [\$20-100]               |
| [05410]   | [Adjust complete denture – maxillary]  | [\$15-100]               |
| [05411]   | [Adjust complete denture – mandibular]   | [\$15-100]               |
| [05421]   | [Adjust partial denture – maxillary]   | [\$15-100]               |
| [05422]   | [Adjust partial denture – mandibular]  | [\$15-100]               |
| [05510]   | [Repair broken complete denture base]  | [\$50-150]               |
| [05520]   | [Replace missing or broken teeth – complete denture (each tooth)]                    | [\$15-100]               |
| [05610]   | [Repair resin denture base]  | [\$20-150]               |

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|---------|--|-------------|
| [05620] | [Repair cast framework]  | [\$20-200]  |
| [05630] | [Repair or replace broken clasp]                                     | [\$25-150]  |
| [05640] | [Replace broken teeth – per tooth]                                   | [\$15-100]  |
| [05650] | [Add tooth to existing partial denture]                              | [\$30-150]  |
| [05660] | [Add clasp to existing partial denture]                              | [\$25-150]  |
| [05670] | [Replace all teeth and acrylic on case metal framework (maxillary)]  | [\$60-350]  |
| [05671] | [Replace all teeth and acrylic on case metal framework (mandibular)] | [\$60-350]  |
| [05710] | [Rebase complete maxillary denture]                                  | [\$60-350]  |
| [05711] | [Rebase complete mandibular denture]                                 | [\$60-350]  |
| [05720] | [Rebase maxillary partial denture]                                   | [\$60-350]  |
| [05721] | [Rebase mandibular partial denture]                                  | [\$60-350]  |
| [05730] | [Reline complete maxillary denture (chairside)]                      | [\$35-200]  |
| [05731] | [Reline complete mandibular denture (chairside)]                     | [\$35-200]  |
| [05740] | [Reline maxillary partial denture (chairside)]                       | [\$35-200]  |
| [05741] | [Reline mandibular partial denture (chairside)]                      | [\$35-200]  |
| [05750] | [Reline complete maxillary denture (laboratory)]                     | [\$50-350]  |
| [05751] | [Reline complete mandibular denture (laboratory)]                    | [\$50-350]  |
| [05760] | [Reline maxillary partial denture (laboratory)]                      | [\$45-350]  |
| [05761] | [Reline mandibular partial denture (laboratory)]                     | [\$45-350]  |
| [05850] | [Tissue conditioning, maxillary]                                     | [\$15-100]  |
| [05851] | [Tissue conditioning, mandibular]                                    | [\$15-100]  |
| [06930] | [Re-cement fixed partial denture]                                    | [\$20-150]] |

| <b>[Major Dental Services Benefits:</b>   |   |                           |
|---|---|---------------------------|
| [Benefits for all covered Major Dental Services rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [\$100-50,000] [per Covered Person.]]  |   |                           |
| [All benefits for covered Major Dental Services are subject to the Basic and Major Services Combined Maximum Benefit Limitation shown on this Policy Schedule.]   |   |                           |
| [The Scheduled Benefits shown below will be reduced by [5-100]% for any covered procedure rendered during the first [[180-365] calendar day period][[1-2] Policy Year[s]] following the Effective Date. [The Scheduled Benefits shown below will be reduced by [5-100]% for any covered procedure rendered during the second [[180-365] calendar day period][Policy Year] following the Effective Date.]] |   |                           |
| <b>Procedure Code</b>   | <b>[Major Dental Services]</b>                          | <b>Scheduled Benefits</b> |
| [02510]   | [Inlay – metallic – one surface]                        | [\$155-450]               |
| [02520]   | [Inlay – metallic – two surfaces]                       | [\$180-500]               |
| [02530]   | [Inlay – metallic – three or more surfaces]             | [\$210-550]               |
| [02543]   | [Onlay – metallic – three surfaces]                     | [\$210-550]               |
| [02544]   | [Onlay – metallic – four or more surfaces]              | [\$210-550]               |
| [02610]   | [Inlay – porcelain/ceramic – one surface]               | [\$180-450]               |
| [02620]   | [Inlay – porcelain/ceramic – two surfaces]              | [\$180-450]               |
| [02630]   | [Inlay – porcelain/ceramic – three or more surfaces]    | [\$210-550]               |
| [02642]   | [Onlay – porcelain/ceramic – two surfaces]              | [\$210-550]               |
| [02643]   | [Onlay – porcelain/ceramic – three surfaces]            | [\$210-550]               |
| [02644]   | [Onlay – porcelain/ceramic – four or more surfaces]     | [\$210-550]               |
| [02650]   | [Inlay – resin-based composite – one surface]           | [\$125-350]               |
| [02651]   | [Inlay – resin based composite – two surfaces]          | [\$130-400]               |
| [02662]   | [Onlay – resin based composite – two surfaces]          | [\$145-400]               |
| [02663]   | [Onlay – resin based composite – three surfaces]        | [\$155-450]               |
| [02910]   | [Re-cement inlay]                                       | [\$20-150]                |
| [02940]   | [Sedative Filling]                                      | [\$20-150]                |
| [02951]   | [Pin retention – per tooth, in addition to restoration] | [\$10-100]                |

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|---------|---|-------------|
| [02710] | [Crown – resin laboratory]  | [\$80-350]  |
| [02720] | [Crown –resin with high noble metal]  | [\$180-650] |
| [02721] | [Crown – resin with predominantly base metal]   | [\$180-650] |
| [02722] | [Crown – resin with noble metal]  | [\$180-650] |
| [02740] | [Crown – porcelain/ceramic substrate]   | [\$180-650] |
| [02750] | [Crown – porcelain fused to high noble metal]   | [\$180-650] |
| [02751] | [Crown – porcelain fused to predominantly base metal]   | [\$180-650] |
| [02752] | [Crown – porcelain fused to noble metal]  | [\$180-650] |
| [02780] | [Crown – ¾ case high noble metal]   | [\$180-650] |
| [02781] | [Crown – ¾ case predominantly base metal]   | [\$180-650] |
| [02782] | [Crown – ¾ cast noble metal]  | [\$180-650] |
| [02790] | [Crown porcelain]   | [\$180-650] |
| [02791] | [Crown - full cast predominantly base metal]  | [\$180-650] |
| [02792] | [Crown – full cast noble metal]   | [\$180-650] |
| [02810] | [Crown – ¾ cast metallic]   | [\$180-650] |
| [02920] | [Re-cement crown]   | [\$20-150]  |
| [02930] | [Prefabricated stainless steel crown – primary tooth]   | [\$40-200]  |
| [02931] | [Prefabricated stainless steel crown – permanent tooth]   | [\$50-250]  |
| [02932] | [Prefabricated resin crown]   | [\$55-250]  |
| [02933] | [Prefabricated stainless steel crown with resin window]   | [\$60-250]  |
| [02940] | [Sedative filling]  | [\$20-150]  |
| [02950] | [Core buildup, including any pins]  | [\$40-200]  |
| [02952] | [Cast post and core in addition to crown]   | [\$60-250]  |
| [02954] | [Prefabricated post and core in addition to crown]  | [\$55-250]  |
| [02970] | [Temporary crown (fractured tooth)]   | [\$35-200]  |
| [03110] | [Pulp cap – direct (excluding final restoration)]   | [\$10-100]  |
| [03120] | [Pulp cap – indirect (excluding final restoration)]   | [\$10-100]  |
| [03220] | [Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medication] | [\$30-150]  |
| [03310] | [Anterior (excluding final restoration)]  | [\$120-350] |
| [03320] | [Bicuspid (excluding final restoration)]  | [\$150-450] |
| [03330] | [Molar (excluding final restoration)]   | [\$210-550] |
| [03346] | [Retreatment of previous root canal therapy – anterior]   | [\$120-350] |
| [03347] | [Retreatment of previous root canal therapy – bicuspid]   | [\$150-400] |
| [03348] | [Retreatment of previous root canal therapy – molar]  | [\$240-600] |
| [03410] | [Apicoectomy/periradicular surgery – anterior]  | [\$115-300] |
| [03421] | [Apicoectomy/periradicular surgery – bicuspid (first root)]   | [\$155-500] |
| [03425] | [Apicoectomy/periradicular surgery – molar (first root)]  | [\$205-500] |
| [03426] | [Apicoectomy/periradicular surgery – (each additional root)]  | [\$60-250]  |
| [03430] | [Retrograde filling – per root]   | [\$40-200]  |
| [03450] | [Root amputation – per root]  | [\$85-350]  |
| [03920] | [Hemisection (including any root removal), not including root canal therapy]  | [\$65-250]  |
| [00180] | [Comprehensive periodontal evaluation – new or established patient]   | [\$10-100]  |
| [04210] | [Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant]  | [\$110-300] |
| [04211] | [Gingivectomy or gingivoplasty – one to three teeth – per quadrant]   | [\$40-150]  |
| [04240] | [Gingival flap procedure, including root planning – four or more contiguous teeth or bounded teeth spaces per quadrant]                       | [\$150-450] |
| [04249] | [Clinical crown lengthening – hard tissue]  | [\$215-450] |
| [04260] | [Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant]                     | [\$205-500] |
| [04261] | [Osseous surgery (including flap entry and closure) – one to three teeth, per quadrant]   | [\$100-350] |
| [04263] | [Bone replacement graft – first site in quadrant]   | [\$60-250]  |
| [04264] | [Bone replacement graft – each additional site in quadrant]   | [\$30-150]  |

|         |  |             |
|---------|--|-------------|
| [04270] | [Pedicle soft tissue graft procedure]  | [\$150-450] |
| [04271] | [Free soft tissue graft procedure (including donor site surgery)]  | [\$150-450] |
| [04341] | [Periodontal scaling and root planning – four or more contiguous teeth or bounded teeth spaces per quadrant]                       | [\$35-200]  |
| [04355] | [Full mouth debridement to enable comprehensive evaluation and diagnosis]  | [\$25-150]  |
| [04910] | [Periodontal maintenance]  | [\$25-150]  |
| [05110] | [Complete denture – maxillary]   | [\$190-550] |
| [05120] | [Complete denture – mandibular]  | [\$190-550] |
| [05130] | [Immediate denture – maxillary]  | [\$205-550] |
| [05140] | [Immediate denture – mandibular]   | [\$205-550] |
| [05211] | [Maxillary partial denture – resin base (including any conventional clasps, rests, and teeth)]                                     | [\$155-550] |
| [05212] | [Mandibular partial denture – resin base (including any conventional clasps, rests, and teeth)]                                    | [\$180-550] |
| [05213] | [Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)]  | [\$210-550] |
| [05214] | [Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)] | [\$210-550] |
| [05281] | [Removable unilateral partial denture – one piece cast metal (including clasps and teeth)]   | [\$120-450] |
| [06210] | [Pontic – cast high noble metal]   | [\$180-600] |
| [06211] | [Pontic – cast predominantly base metal]   | [\$180-600] |
| [06212] | [Pontic – cast noble metal]  | [\$180-600] |
| [06240] | [Pontic – porcelain fused to high noble metal]   | [\$180-600] |
| [06241] | [Pontic – porcelain fused to predominantly base metal]   | [\$180-600] |
| [06242] | [Pontic – porcelain fused to noble metal]  | [\$180-600] |
| [06250] | [Pontic – resin with high noble metal]   | [\$180-600] |
| [06251] | [Pontic – resin with predominantly base metal]   | [\$180-600] |
| [06252] | [Pontic – with noble metal]  | [\$180-600] |
| [06545] | [Retainer – cast metal for resin bonded fixed prosthesis]  | [\$70-300]  |
| [06602] | [Inlay – cast high noble metal, two surfaces]  | [\$180-600] |
| [06603] | [Inlay – cast high noble metal, three or more surfaces]  | [\$180-600] |
| [06604] | [Inlay – cast predominantly base metal, two surfaces]  | [\$180-600] |
| [06605] | [Inlay – cast predominantly base metal, three or more surfaces]  | [\$180-600] |
| [06606] | [Inlay – cast noble metal, two surfaces]   | [\$180-600] |
| [06607] | [Inlay – cast noble metal three or more surfaces]  | [\$180-600] |
| [06610] | [Onlay – cast high noble metal, two surfaces]  | [\$180-600] |
| [06611] | [Onlay – cast high noble metal, three or more surfaces]  | [\$180-600] |
| [06612] | [Onlay – cast predominantly base metal, two surfaces]  | [\$180-600] |
| [06613] | [Onlay – cast predominantly base metal, three or more surfaces]  | [\$180-600] |
| [06614] | [Onlay – cast noble metal, two surfaces]   | [\$180-600] |
| [06615] | [Onlay – cast noble metal, three or more surfaces]   | [\$180-600] |
| [06720] | [Crown – resin with high noble metal]  | [\$180-600] |
| [06721] | [Crown – resin with predominantly base metal]  | [\$180-600] |
| [06722] | [Crown – resin with noble metal]   | [\$180-600] |
| [06740] | [Crown – porcelain/ceramic]  | [\$180-600] |
| [06750] | [Crown – porcelain fused to high noble metal]  | [\$180-600] |
| [06751] | [Crown – porcelain fused to predominantly base metal]  | [\$180-600] |
| [06752] | [Crown – porcelain fused to noble metal]   | [\$180-600] |
| [06780] | [Crown – ¾ cast high noble metal]  | [\$180-600] |
| [06781] | [Crown – ¾ cast predominantly base metal]  | [\$180-600] |
| [06782] | [Crown ¾ cast noble metal]   | [\$180-600] |
| [06783] | [Crown ¾ cast porcelain/ceramic]   | [\$180-600] |
| [06790] | [Crown – full cast high noble metal]   | [\$180-600] |
| [06791] | [Crown – full cast predominantly base metal]   | [\$180-600] |

|         |   |              |
|---------|---|--------------|
| [06792] | [Crown – full cast noble metal]   | [\$180-600]  |
| [07210] | [Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth]  | [\$35-200]   |
| [07220] | [Removal of impacted tooth – soft tissue]   | [\$50-200]   |
| [07230] | [Removal of impacted tooth – partially bony]  | [\$65-300]   |
| [07240] | [Removal of impacted tooth – completely bony]   | [\$70-350]   |
| [07241] | [Removal of impacted tooth – completely bony, with unusual surgical complications]  | [\$95-350]   |
| 07250]  | [Surgical removal of residual tooth roots (cutting procedure)]  | [\$40-250]   |
| [07260] | [Oroantral fistula closure]   | [\$330-1200] |
| [07270] | [Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth]  | [\$85-350]   |
| [07280] | [Surgical access of unerupted tooth]  | [\$90-350]   |
| [07281] | [Surgical exposure of impacted or unerupted tooth to aid eruption]  | [\$65-300]   |
| [07285] | [Biopsy of oral tissue – hard (bone, tooth)]  | [\$150-500]  |
| [07286] | [Biopsy of oral tissue – soft (all others)]   | [\$65-300]   |
| [07310] | [Alveoloplasty in conjunction with extractions – per quadrant]  | [\$40-200]   |
| [07320] | [Alveoloplasty not in conjunction with extractions – per quadrant]  | [\$170-600]  |
| [07340] | [Vestibuloplasty – ridge extension (secondary epithelialization)]   | [\$420-1100] |
| [07350] | [Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachments and management of hypertrophied tissue)] | [\$500-1200] |
| [07410] | [Excision of benign lesion up to 1.25 cm]   | [\$65-300]   |
| [07411] | [Excision of benign lesion greater than 1.25 cm]  | [\$240-750]  |
| [07413] | [Excision of malignant lesion up to 1.25 cm]  | [\$65-300]   |
| [07414] | [Excision of malignant lesion greater than 1.25 cm]   | [\$270-800]  |
| [07450] | [Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm.]  | [\$65-300]   |
| [07451] | [Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm]  | [\$240-700]  |
| [07460] | [Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm]  | [\$145-500]  |
| [07461] | [Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm]   | [\$240-750]  |
| [07471] | [Removal of lateral exostosis (maxilla or mandible)]  | [\$145-500]  |
| [07510] | [Incision and drainage of abscess – intraoral soft tissue]  | [\$40-200]   |
| [07520] | [Incision and drainage of abscess – extraoral soft tissue]  | [\$180-650]  |
| [07530] | [Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue]  | [\$65-300]   |
| [07540] | [Removal of reaction producing foreign bodies, musculoskeletal system]  | [\$80-350]   |
| [07550] | [Partial ostectomy/sequestrectomy for removal of non-vital bone]  | [\$50-250]   |
| [07560] | [Maxillary sinusotomy for removal of tooth fragment or foreign body]  | [\$480-1100] |
| [07960] | [Frenulectomy (frenectomy or frenotomy) - separate procedure]   | [\$90-350]   |
| [07970] | [Excision of hyperplastic tissue – per arch]  | [\$90-350]   |
| [07971] | [Excision of pericoronal gingival]  | [\$30-200]   |
| [07972] | [Surgical reduction of fibrous tuberosity]  | [\$115-400]  |
| [07980] | [Sialodochoplasty]  | [\$140-450]  |

|  |
|--|
| <b>[Temporomandibular Joint Services Benefits:</b>   |
| [Temporomandibular Joint Services Benefit Waiting Period: Temporomandibular Joint Services Benefits under this Policy are only payable for covered procedures rendered after[[180-365] calendar days] [1-3] Policy Year[s] from the Effective Date.]   |
| [Benefits for all covered Temporomandibular Joint Services rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [\$100-50,000] [per Covered Person].]  |
| [Benefits for all covered Temporomandibular Joint Services are limited to a maximum lifetime benefit of [\$100-50,000] [per Covered Person]. Once this maximum has been met, no additional Temporomandibular Joint Services Benefits are available [for that Covered Person] under this Policy.] |
| [The Scheduled Benefits shown below will be reduced by [5-100]% for any covered procedure rendered during the first [ [1-3]Policy Year[s]] following the [Effective Date][end of the Benefit Waiting Period].]   |

| <b>Procedure Code</b> | <b>Temporomandibular Joint Services</b>                           | <b>Scheduled Benefit</b> |
|-----------------------|---|--------------------------|
| [00320]               | [Temporomandibular joint arthrogram, including injection]         | [\$130-450]              |
| [07610]               | [Maxilla – open reduction (teeth immobilized, if present)]        | [\$500-600]              |
| [07620]               | [Maxilla – closed reduction (teeth immobilized, if present)]      | [\$485-600]              |
| [07630]               | [Mandible - open reduction (teeth immobilized, if present)]       | [\$500-600]              |
| [07640]               | [Mandible - closed reduction (teeth immobilized, if present)]     | [\$500-600]              |
| [07650]               | [Malar and/or zygomatic arch – open reduction]                    | [\$400-600]              |
| [07660]               | [Malar and/or zygomatic arch – closed reduction]                  | [\$240-600]              |
| [07670]               | [Alveolus – closed reduction, may include stabilization of teeth] | [\$185-600]              |
| [07671]               | [Alveolus – open reduction, may include stabilization of teeth]   | [\$350-600]              |
| [07710]               | [Maxilla – open reduction]  | [\$500-600]              |
| [07720]               | [Maxilla – closed reduction]                                      | [\$500-600]              |
| [07730]               | [Mandible – open reduction]                                       | [\$500-600]              |
| [07740]               | [Mandible – closed reduction]                                     | [\$500-600]              |
| [07820]               | [Closed reduction of dislocation]                                 | [\$115-400]              |
| [07870]               | [Arthrocentesis]  | [\$50-200]               |
| [07880]               | [Occlusal orthotic device, by report]                             | [\$110-400]              |

|  |   |
|--|---|
| <b>[Orthodontic Benefits:</b>  |   |
| [Orthodontic Benefits are payable only after satisfaction of the Orthodontic Dental Services Benefit Waiting Period. The Orthodontic Dental Services Benefit Waiting Period is [1-3] Policy Year[s] following the Effective Date of coverage.]   |   |
| [Benefits for all covered Orthodontic Treatment rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [\$100-50,000] per Covered Person.] [Benefits for all covered Orthodontic Treatment rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [\$100-50,000] for all Covered Persons combined.]                      |   |
| [Benefits for all covered Orthodontic Treatment are limited to a maximum lifetime benefit of [\$100-50,000] [per Covered Person]. Once this maximum has been met, no additional Orthodontic Benefits are available [for that Covered Person] under this policy.]   |   |
| [We will pay [actual charges incurred] up to [\$200-600] for the initial Orthodontic Treatment consisting of one or more of the Orthodontic Dental Services listed below. Thereafter a fixed indemnity benefit of \$[200-600] is payable once [every three months] [every month] for continued Orthodontic Treatment involving one or more of the Orthodontic Dental Services listed below.] |   |
| <b>Procedure Code</b>  | <b>Orthodontic Dental Services</b>  |
| [00340]  | [Cephalometric film]  |
| [00350]  | [Oral/facial images (includes intra and extraoral images)]                              |
| [00470]  | [Diagnostic casts]  |
| [08030]  | [Limited orthodontic treatment of adolescent dentition]                                 |
| [08080]  | [Comprehensive orthodontic treatment of the adolescent dentition]                       |
| [08210]  | [Removable appliance therapy]   |
| [08220]  | [Fixed appliance therapy]   |
| [08660]  | [Pre-orthodontic therapy]   |
| [08670]  | [Periodic orthodontic treatment visit (as part of contract)]                            |
| [08680]  | [Orthodontic retention (removal of appliance, construction and placement of retainers)] |

**[AGENT INFORMATION]**

[Name

Address & Telephone Number]



[6.] Email Address: \_\_\_\_\_

[7.] [Is the [Primary] [Proposed] [Insured] a U.S. citizen or Lawful Permanent Resident/Green Card Holder?  Yes  No ]

[8.] [Is the [Primary] [Proposed] [Insured] a dentist, dental hygienist, or employed in a dental office or clinic or as an insurance agent? .....  Yes  No ]

[9a.] [[Primary] [Proposed] [Insured] Primary Occupation [and Job Title] : \_\_\_\_\_ ]

[Duties: \_\_\_\_\_ ]

[9b.] [[Primary] [Proposed] [Insured] Primary Industry: \_\_\_\_\_ ] [Standard Industrial Classification (SIC) code: \_\_\_\_\_ ]

[9c.] [Primary Employer's Name: \_\_\_\_\_ ]

[Employer's Phone Number: (\_\_\_\_\_) \_\_\_\_\_ ]

[Employer's Address: \_\_\_\_\_ (Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State ) \_\_\_\_\_ (Zip) ]

[Type of Business: \_\_\_\_\_ ]

**OTHER COVERAGE IN FORCE**

[10.] [[Are any of] [Is] the [Primary] [Proposed] [Insured][s] covered by, or has [application][enrollment] been made for any type of [dental] [or] [medical] insurance? .....  Yes  No ]

[If "Yes," complete the section below.

| Insurance Company Name | Policy Number | Phone Number (include area code) | Effective Date (MM/DD/YY) | Is this coverage being replaced by proposed coverage? |
|------------------------|---------------|----------------------------------|---------------------------|---|
|                        |               |                                  |                           |   |
|                        |               |                                  |                           |   |

**EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT**

You understand and agree that you are applying for dental insurance for you [(and your family)]. You further understand this application for dental insurance [will] [may] [be] [fully] [medically] [underwritten] [,] [and] [is subject to eligibility requirements.] You are personally paying the entire premium for this dental insurance coverage.

Your employer is not contributing in any way to the payment of premium, either directly or indirectly.

[[If my employer has [2]-[50] full-time employees,] I agree that I will not use [employer contributions] [or] [funds from a [Health Reimbursement Arrangement] [(HRA)] [or a Cafeteria Plan]] to pay the premium for my individual coverage.]

Do you agree with this statement? .....  Yes  No ]

**[FAX ALL PAGES EXCEPT "IMPORTANT NOTICES" TO [866.387.0486]]**

Assurant Health 501 West Michigan Milwaukee, WI 53203 [Fax 414-299-6020]

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company.



## **IMPORTANT NOTICES - LEAVE WITH CUSTOMER**

### **[ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES**

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.]

### **[FRAUD NOTICE**

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.]

### **[PRIVACY**

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on application forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.]

**[FAX ALL PAGES EXCEPT "IMPORTANT NOTICES" TO [866.387.0486]]**

Assurant Health 501 West Michigan Milwaukee, WI 53203 [Fax 414-299-6020]

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company.

DENTAL INDEMNITY INSURANCE  
OUTLINE OF COVERAGE FOR  
POLICY FORM 8079.POL.AR

THE POLICY PROVIDES LIMITED BENEFITS

THE POLICY PROVIDES COVERAGE FOR DENTAL BENEFITS ONLY AND  
DOES NOT PROVIDE REIMBURSEMENT OF MEDICAL EXPENSES

THIS IS NOT A MEDICARE SUPPLEMENT POLICY

**READ YOUR POLICY CAREFULLY:** This outline of coverage provides a very brief description of the important features of the Policy. This is not the insurance Policy and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both You and Time Insurance Company. It is, therefore, important that You **READ YOUR POLICY CAREFULLY!**

**DENTAL INDEMNITY COVERAGE:** Policies of this category are designed to provide, to the person insured, benefits when specified dental procedures are rendered, subject to any limitations set forth in the Policy and in the amount shown on the Policy Schedule. Coverage is not provided for basic hospital, basic medical-surgical or major medical expenses.

**DENTAL COVERAGE INFORMATION**

[Benefit Waiting Period: Benefits under the Policy[, except Dental Preventive Benefits,] are payable after [30-180] calendar days from the Effective Date [unless as otherwise specified].]

[Basic and Major Services Combined Maximum Benefit Limitation: Benefits for all covered Basic Dental Services and Major Dental Services combined are limited to a maximum Calendar Year benefit of [\$100-50,000] [per Covered Person]. This benefit limitation is in addition to any other maximum benefit limitation specified below.]

**Dental Preventive Benefits:** We will pay one Dental Preventive Benefit of \$[xxx], regardless of the number of visits to a Dentist or Dental Hygienist or the number of services received, every [90-270] calendar days. Dental Preventive Benefits are limited to a maximum benefit of [\$100 - \$50,000] per Calendar Year.

[Basic Dental Services Benefits: We will pay the Scheduled Benefit for Basic Dental Services as show on the Policy Schedule. [The Scheduled Benefit will be reduced by [xx]% for all Basic Dental Services rendered during the first [[180-365] calendar days] [1-2] [Policy Year][s] following the Effective Date of coverage. ] [All benefits for Basic Dental Services rendered during the same Calendar Year are subject to a maximum Calendar Year benefit limitation of \$\_\_\_\_\_.] [All benefits for covered Basic Dental Services are subject to the Basic and Major Services Combined Maximum Benefit.]]

[Major Dental Services Benefits: We will pay the Scheduled Benefit for Major Dental Services as show on the Policy Schedule. [The Scheduled Benefit will be reduced by [xx]% for all Major Dental Services rendered during the first [[180-365] calendar days] [1-2][Policy Year][s] following the Effective Date of coverage.] [The Scheduled Benefit will be reduced by [xx]% for all Major Dental Services rendered during the second [[180-365] calendar days] [1-2] [Policy Year][s] following the Effective Date of coverage.] [All benefits for Major Dental Services rendered during the same Calendar Year are subject to a maximum Calendar Year benefit limitation of \$\_\_\_\_\_.] [All benefits for covered Major Dental Services are subject to the Basic and Major Services Combined Maximum Benefit.]]

[Temporomandibular Joint Services Benefits

We will pay the Scheduled Benefit for Temporomandibular Joint Services as show on the Policy Schedule [after a Benefit Waiting Period of [[180-365] calendar days] [1-3] [Policy Year][s]]. [The Scheduled Benefit will be reduced by [xx]% for all Temporomandibular Joint Services rendered during the first [1-3] [Policy Year][s] following the [Effective Date of coverage][end of the Benefit Waiting Period].] [Thereafter the full Scheduled Benefit will be paid for covered Temporomandibular Joint Services.] [All benefits for Temporomandibular Joint Services rendered during the same Calendar Year are subject to a maximum Calendar Year benefit limitation of \$[\_\_\_\_\_].] [All benefits for Temporomandibular Joint Services are subject to a maximum lifetime benefit limitation of \$[\_\_\_\_\_] per Covered Person.]]

[Orthodontic Benefits

[The Orthodontic Dental Services Benefit Waiting Period is [1-3] Policy Year[s] following the Effective Date of coverage.] [Only Covered Persons who are under age [18] years are eligible for Orthodontic Benefits. Orthodontic Treatment must have been initiated prior to the Covered Person's [17<sup>th</sup>] birthday. Benefits for Orthodontic Treatment cease upon attainment of the Covered Person's [18<sup>th</sup>] birthday.] [We will pay benefits for the Orthodontic Dental Services listed on the Policy Schedule when the treatment for Orthodontic Dental Service begins while the Covered Person is insured under the plan. No payment will be made for the Orthodontic Dental Service if the appliances or bands are inserted prior to becoming insured. We consider Orthodontic Treatment to be started on the date the bands or appliances are inserted. Any other Orthodontic Treatment that can be completed on the same day it is rendered is considered to be started and completed on the date the Orthodontic Treatment is rendered.] [We will make a payment for covered orthodontic services related to the initial Orthodontic Treatment, which consists of diagnosis, evaluation, pre-care and insertion of bands or appliances. After the payment for the initial Orthodontic Treatment, benefits for covered Orthodontic Dental Services will be paid in equal [monthly] [quarterly] payments over the course of the remaining Orthodontic Treatment. The initial Orthodontic Treatment and [quarterly] [monthly] indemnity benefit amounts are shown on the Policy Schedule.]

[Benefits for all covered Orthodontic Treatment rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of \$[\_\_\_\_\_] per Covered Person.] [Benefits for all covered Orthodontic Treatment rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of \$[\_\_\_\_\_] for all Covered Persons combined.]

[Benefits for all covered Orthodontic Treatment are limited to a maximum lifetime benefit of \$[\_\_\_\_\_] [per Covered Person]. ]

EXCLUSIONS AND LIMITATIONS:

This Policy pays limited, fixed indemnity benefits for Dental Treatments only. See the Policy Schedule for the limited benefit amounts and maximum benefit limitations.

[We will not pay benefits for any of the following:

1. [any procedure or treatment not shown on the Policy Schedule.]
2. [any procedure rendered during an applicable Benefit Waiting Period.]
3. [any amount in excess of a Calendar Year or lifetime maximum benefit limitation.]
4. [Dental Preventive Benefits when there is less than [90-270] calendar days between the dates of service for Dental Preventive Services.]

5. [all Experimental or Investigative Services.]
6. [any procedure performed by a person other than a Dentist or Dental Hygienist.]
7. [any procedure performed by a Covered Person's Immediate Family Member.]
8. [all services that are not Dentally Necessary.]
9. [repairs to dental work less than [30-180] calendar days following completion of the initial procedure.]
10. [prosthetics replaced less than [xx] years following the previous placement.]
11. [crowns replaced less than [xx] years following the previous placement.]
12. [inlays or onlays replaced less than [XXX] years following the last placement.]
13. [dental implants or the removal of implants.]
14. [Cosmetic Services, unless performed to correct a functional disorder.]
15. [services performed outside the United States [and][,] [its territories] [and Canada] except for services that are received for Emergency Dental Treatment.]
16. [replacement of any tooth missing prior to the Effective Date.]
17. [placement of full or partial dentures, whether removable or fixed, including a Maryland Bridge, unless replacing a Functioning Natural Tooth extracted after the Effective Date[and not within a Benefit Waiting Period].]
18. [for Covered Persons under age 16, inlays, onlays, bridgework or crowns except for stainless steel or plastic crowns.]
19. [any charge or procedure for treatment required because of Dental Injury or disease due to:
  - a. [war or any act of war, whether declared or undeclared.]
  - b. [participation in the military service of any country or international organization[,including non-military units supporting such forces.]]
  - c. [charges for Sickness or Injury caused or aggravated by attempted suicide or self-inflicted Sickness or Injury, even if the Covered Person did not intend to cause the harm which resulted from the action which led to the self-inflicted Sickness or Injury.]
  - d. [taking part in a riot or insurrection, or an act of riot or insurrection.]
  - e. [participating in, voluntarily attempting to commit or commission of a felony, whether or not charged, or engaging in an illegal occupation or activity at the time of an Accident.]
  - f. [voluntary use of any controlled substance, as defined by statute, except when administered in accordance with the advice of the Covered Person's health care practitioner.]
  - g. [riding in any aircraft not licensed to carry passengers or not operated by a duly licensed pilot.]
  - h. [charges for treatment or services required due to an Injury sustained in operating a motor vehicle while the Covered Person's blood alcohol level, as defined by law, was [.08] or higher. This exclusion applies whether or not the Covered Person is charged with any violation in connection with the Accident.]
20. [procedures rendered before the Effective Date or after the termination date of coverage.]
21. [orthodontic treatment and services.]

[In addition to the Exclusions listed above, the following exclusion applies to Orthodontic Dental Services coverage:

We will not pay benefits for Orthodontic Treatment procedures rendered after the Covered Person's [18<sup>th</sup>] birthday.]

RENEWABILITY PROVISION: The policy is guaranteed renewable until 12:01 a.m. local time at the Policyholder's state of residence on the earliest of the following dates:

1. the date We receive a request in writing or by telephone to terminate this plan or on a later date that is requested by the Policyholder for termination.
2. the date We receive a request in writing or by telephone to terminate coverage for a Covered Dependent or on a later date that is requested by the Policyholder for termination of a Covered Dependent.
3. the date this plan lapses for nonpayment of premium per the Grace Period provision in the Premium Provisions section.
4. [the date there is fraud or material misrepresentation made by or with the knowledge of any Covered Person [applying for this coverage or] filing a claim for benefits.]
5. [the date all policies with the same form number as this Policy are non-renewed in the state in which this Policy was issued or the state in which the Policyholder presently resides.]
6. [the date We terminate or non-renew [health][dental] insurance coverage in the individual market in the state in which this Policy was issued or the state in which You presently reside. We will give You advance notice, as required by state law, of the termination of Your coverage.]
7. [[on][t]he date the Policyholder moves to a state where We do not provide insurance coverage under the same plan as this Policy[, We reserve the right to terminate this coverage].]
8. [for a Covered Dependent: on the date a Covered Dependent no longer meets the Dependent definition in this plan.]
9. [the date the Policyholder attains age [65-75] years.] [The anniversary date of this Policy following the Policyholder's [65<sup>th</sup> - 75<sup>th</sup>] birthday.]

|                                      |
|--------------------------------------|
| <b>PREMIUM INFORMATION</b>           |
| Premium Payment Mode: _____          |
| INITIAL MODAL PREMIUM AMOUNT: _____  |
| INITIAL ANNUAL PREMIUM AMOUNT: _____ |

Your premium may be adjusted from time to time based on different factors including, but not limited to, Your geographic area, [gender,] [age,] payment method and plan design. All premium adjustments will be made to individuals on the basis of shared characteristics. The premium may also change if You add or delete Covered Dependents, change the payment method, move to another zip code or otherwise change the coverage.

\_\_\_\_\_  
Licensed Agent's Signature

\_\_\_\_\_  
Date

SERFF Tracking Number: MCHX-126415671 State: Arkansas  
 Filing Company: Time Insurance Company State Tracking Number: 44308  
 Company Tracking Number: 8035.POL.AR  
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental  
 Product Name: 8079.POL.XX Individual Dental Indemnity Policy - T  
 Project Name/Number: 8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company /8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company

**Rate Information**

Rate data applies to filing.

**Filing Method:** Prior Approval  
**Rate Change Type:** %  
**Overall Percentage of Last Rate Revision:** %  
**Effective Date of Last Rate Revision:**  
**Filing Method of Last Filing:**

**Company Rate Information**

| Company Name:          | Overall % Indicated Change: | Overall % Rate Impact: | Written Premium Change for this Program: | # of Policy Holders Affected for this Program: | Written Premium for this Program: | Maximum % Change (where required): | Minimum % Change (where required): |
|------------------------|-----------------------------|------------------------|--|--|-----------------------------------|------------------------------------|------------------------------------|
| Time Insurance Company | %                           | %                      |  |  |                                   | %                                  | %                                  |

SERFF Tracking Number: MCHX-126415671 State: Arkansas  
 Filing Company: Time Insurance Company State Tracking Number: 44308  
 Company Tracking Number: 8035.POL.AR  
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental  
 Product Name: 8079.POL.XX Individual Dental Indemnity Policy - T  
 Project Name/Number: 8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company /8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company

## Supporting Document Schedules

|                          |                      | <b>Item Status:</b> | <b>Status Date:</b> |
|--------------------------|----------------------|---------------------|---------------------|
| <b>Satisfied - Item:</b> | Application          | Approved-Closed     | 12/28/2009          |
| <b>Comments:</b>         | Please see forms tab |                     |                     |

|                          |                      | <b>Item Status:</b> | <b>Status Date:</b> |
|--------------------------|----------------------|---------------------|---------------------|
| <b>Satisfied - Item:</b> | Outline of Coverage  | Approved-Closed     | 12/28/2009          |
| <b>Comments:</b>         | Please see forms tab |                     |                     |

|                          |                          | <b>Item Status:</b> | <b>Status Date:</b> |
|--------------------------|--------------------------|---------------------|---------------------|
| <b>Satisfied - Item:</b> | Revised Form Listing     | Approved-Closed     | 12/28/2009          |
| <b>Comments:</b>         |                          |                     |                     |
| <b>Attachment:</b>       | Revised Form Listing.PDF |                     |                     |

|                          |                                | <b>Item Status:</b> | <b>Status Date:</b> |
|--------------------------|--------------------------------|---------------------|---------------------|
| <b>Satisfied - Item:</b> | 12.09.09 Submission Letter     | Approved-Closed     | 12/28/2009          |
| <b>Comments:</b>         |                                |                     |                     |
| <b>Attachment:</b>       | 12_09_09 Submission Letter.PDF |                     |                     |

|                          |                      | <b>Item Status:</b> | <b>Status Date:</b> |
|--------------------------|----------------------|---------------------|---------------------|
| <b>Satisfied - Item:</b> | Authorization Letter | Approved-Closed     | 12/28/2009          |
| <b>Comments:</b>         |                      |                     |                     |
| <b>Attachment:</b>       |                      |                     |                     |

SERFF Tracking Number: MCHX-126415671 State: Arkansas  
 Filing Company: Time Insurance Company State Tracking Number: 44308  
 Company Tracking Number: 8035.POL.AR  
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental  
 Product Name: 8079.POL.XX Individual Dental Indemnity Policy - T  
 Project Name/Number: 8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company /8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company

Authorization Letter.PDF

|   |                     |               |
|---|---------------------|---------------|
|   | <b>Item Status:</b> | <b>Status</b> |
|   |                     | <b>Date:</b>  |
| <b>Satisfied - Item:</b> Statement of Variability | Approved-Closed     | 12/28/2009    |
| <b>Comments:</b>                                  |                     |               |
| <b>Attachment:</b>                                |                     |               |
| Statement of Variability.PDF                      |                     |               |

|   |                     |               |
|---|---------------------|---------------|
|   | <b>Item Status:</b> | <b>Status</b> |
|   |                     | <b>Date:</b>  |
| <b>Satisfied - Item:</b> Flesch Certification         | Approved-Closed     | 12/28/2009    |
| <b>Comments:</b>                                      |                     |               |
| <b>Attachments:</b>                                   |                     |               |
| AR - READABILITY CERTIFICATION.PDF                    |                     |               |
| AR Cert of Compliance with Rule 19.PDF                |                     |               |
| AR Certificate of Compliance 23-79-138 and R&R 49.PDF |                     |               |

|  |                     |               |
|--|---------------------|---------------|
|  | <b>Item Status:</b> | <b>Status</b> |
|  |                     | <b>Date:</b>  |
| <b>Satisfied - Item:</b> 12.23.09 Objection Response | Approved-Closed     | 12/28/2009    |
| <b>Comments:</b>                                     |                     |               |
| <b>Attachment:</b>                                   |                     |               |
| 12_23_09 Objection Response.PDF                      |                     |               |

|  |                     |               |
|--|---------------------|---------------|
|  | <b>Item Status:</b> | <b>Status</b> |
|  |                     | <b>Date:</b>  |
| <b>Satisfied - Item:</b> 8079.BNS.XX - Redlined with revisions |                     |               |
| <b>Comments:</b>   |                     |               |
| <b>Attachment:</b>   |                     |               |
| 8079_BNS_XX - Redlined with revisions .PDF                     |                     |               |

Dental Indemnity Insurance  
Arkansas Forms Listing

| <u>Form Number</u>   | <u>Form Description</u>                                    |
|----------------------|--|
| 8079.POL.AR          | Dental Policy Cover Page                                   |
| 8079.TOC.XX          | Matrix Insert Section: Table of Contents                   |
| 8079.DEF.AR          | Matrix Insert Section: Definitions                         |
| 8079.DEN.XX          | Matrix Insert Section: Dental Indemnity Insurance Benefits |
| 8079.EXC.XX          | Matrix Insert Section: Exclusions and Limitations          |
| 8079.CLM.AR          | Matrix Insert Section: Claim Provisions                    |
| 8079.PRM.AR          | Matrix Insert Section: Premium Provisions                  |
| 8079.EFF.AR          | Matrix Insert Section: Effective Date and Termination Date |
| 8079.OTH.AR          | Matrix Insert Section: Other Provisions                    |
| 8079.BNS.XX          | Benefit Summary – Dental Insurance                         |
| Form 28565 (10/2009) | Application Form for Dental Insurance                      |
| 8079.OOC.AR          | Outline of Coverage  |

.....  
**McHugh Consulting Resources, Inc.**

December 9, 2009

Jay Bradford  
Insurance Commissioner  
Arkansas Department of Insurance  
Compliance - Life and Health  
1200 West Third Street  
Little Rock, AR 72201-1904

**Sent via SERFF**

**RE: Time Insurance Company**  
NAIC # 69477 FEIN # 39-0658730

**Individual Dental Indemnity Policy**  
**8079.POL.AR, et al - Policy**  
*See Attached Form Listing*

Dear Commissioner Bradford:

McHugh Consulting Resources, Inc. has been requested to file the attached forms on behalf of Time Insurance Company. We have provided an authorization letter for your files.

We are submitting the above captioned forms and rates for your review seeking approval. The forms are new and not intended to replace any other forms currently in use.

This Dental program will be marketed to individuals through agent/broker solicitation. This plan will be offered using the applications herewith submitted or as an integrated offer with other plans using previously filed application or enrollment forms. This program is being concurrently filed in the domicile state of Wisconsin. This dental plan provides indemnity benefits when specified dental procedures are rendered. The scheduled benefit amount for each covered procedure is shown on the Policy Schedule. This plan does not include PPO benefits.

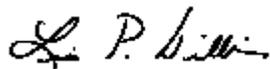
Please note that the Policy is numbered using a matrix format, where each section of the document has a unique form number. For example, the Policy face page is numbered 8079.POL.AR, while the Exclusions section of the same document is numbered 8079.EXC.XX. The Company employs this form numbered style for administrative and tracking purposes. The Policy will always be issued in its entirety with all sections and form numbers included.

These forms are subject to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. Variable data or text is bracketed and a variability statement is enclosed herewith. Variable data will never exclude provisions required by applicable law.

*Commissioner of Insurance  
Time Insurance Company  
Page 2 of 2*

Attached please find any required certifications and/or transmittal forms and filing fees. Please do not hesitate to contact the undersigned at (215) 230-7960 if there are any questions I can answer regarding this filing.

Sincerely,

A handwritten signature in black ink, appearing to read "L. P. Williams". The signature is fluid and cursive, with a small dot above the "i" in "Williams".

Lisa P. Williams, FLMI  
Consultant  
McHugh Consulting Resources, Inc.



**ASSURANT**  
Health

501 West Michigan  
P.O. Box 3050  
Milwaukee, WI 53201-3050  
T 800.800.1212

[www.assurant.com](http://www.assurant.com)

January 2009

Re: Time Insurance Company-NAIC 69477; FEIN 39-0658730

Dear Sir or Madam,

This letter acts as authorization for McHugh Consulting Resources and its representative analysts to file any or all policy forms as referenced on the attached form listing on behalf of the above referenced company and to serve as the primary contact on behalf of the company regarding such filings while under review. Please contact McHugh Consulting Resources with questions or comments regarding the enclosed filing.

Best Regards,

Daniel Ziebell, MHP  
Director Product Compliance  
Worksite, Voluntary and Ancillary Products  
[daniel.ziebell@assurant.com](mailto:daniel.ziebell@assurant.com)  
T 414.299.6045  
F 414.299.6168

Assurant Health markets products underwritten by Time Insurance Company, Union Security Insurance Company and John Alden Life Insurance Company.

### **Statement of Variability**

- All numbers (excluding form numbers) are variable. Numbers within a provision determined by the laws of the governing jurisdiction will be varied only within the confines of the law.
- Paragraphs vary to the extent that such paragraphs may be included, omitted or transferred to another page to suit the needs of a particular policyholder subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular provisions.
- Definitions may vary to the extent that such definition may be included, omitted or transferred to another page to suit the needs of a particular policyholder subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular provisions.
- Items which customarily vary according to the policyholder's specific plan of insurance.

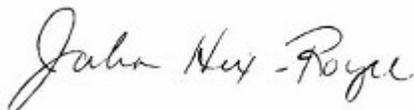
We also reserve the right to amend the attached to fix any minor typographical errors we may have neglected to find prior to submitting for approval and amend the language to clarify the intent within the confines of the law.

**STATE OF ARKANSAS**  
**READABILITY CERTIFICATION**

**COMPANY NAME:** Time Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

| <b>Form Number</b>   | <b>Score</b> |
|----------------------|--------------|
| 8079.POL.AR          | 53           |
| 8079.TOC.XX          | 53           |
| 8079.DEF.AR          | 53           |
| 8079.DEN.XX          | 53           |
| 8079.EXC.XX          | 53           |
| 8079.CLM.AR          | 53           |
| 8079.PRM.AR          | 53           |
| 8079.EFF.XX          | 53           |
| 8079.OTH.AR          | 53           |
| 8079.BNS.XX          | 53           |
| Form 28565 (10/2009) | 43           |
| 8079.OOC.XX          | 54.6         |

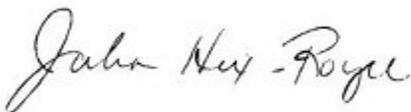
Signed:   
Name: Julia Hix-Royer  
Title: Vice President-Product Compliance  
Date: December 2, 2009

**Certificate of Compliance with  
Arkansas Rule and Regulation 19**

Insurer: Time Insurance Company

Form Number(s): 8079.POL.AR,8079.TOC..XX,8079.DEF.AR,8079.DEN.XX,  
8079.EXC.XX, 8079.CLM.AR, 8079.PRM.AR, 8079.EFF.XX,  
8079.OTH.AR, 8079.BNS.XX, Form 28565 (10/2009), 8079.OOC.XX

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



\_\_\_\_\_  
Signature of Company Officer

\_\_\_\_\_  
Julia Hix-Royer

Name

\_\_\_\_\_  
Vice President, Compliance

Title

\_\_\_\_\_  
December 9, 2009

Date

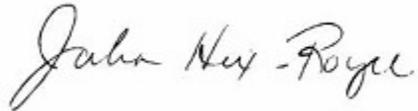
**CERTIFICATE OF COMPLIANCE**

Insurer: Time Insurance Company

Form Numbers:

8079.POL.AR, 8079.TOC..XX,8079.DEF.AR,8079.DEN.XX,  
8079.EXC.XX, 8079.CLM.AR, 8079.PRM.AR, 8079.EFF.XX, 8079.OTH.AR,  
8079.BNS.XX, Form 28565 (10/2009), 8079.OOC.XX

I hereby certify that the filing above meets all applicable Arkansas requirements including Regulation 49 (Life and Health Guaranty Fund Notice) and Ark. Code Ann. 23-79-138 and Bulletin 11-88 (Consumer Information Notice).



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Signature of Company Officer

Julia Hix-Royer

---

Name

Vice President-Compliance

---

Title

December 9, 2009

---

Date

.....

# McHugh Consulting Resources, Inc.

December 23, 2009

Rosalind Minor  
Arkansas Department of Insurance  
Compliance - Life and Health  
1200 West Third Street  
Little Rock, AR 72201-1904

**Sent via SERFF**

**RE: Time Insurance Company**  
NAIC # 69477 FEIN # 39-0658730

**Individual Dental Indemnity Policy**  
**8079.POL.AR, et al - Policy**  
*See Attached Form Listing*  
**SERFF Tracking. No. MCHX-126415671**  
**State Assigned No. 44308**  
**DEPARTMENT LETTER DATED: December 15, 2009**

Dear Ms. Minor:

Thank you for your letter dated December 15, 2009 regarding the captioned submission. Please note that we have responded to your concerns in the order in which they appear in your letter.

1. Pursuant to ACA 23-79-129(b), we have revised the first sentence of the Adding a Newborn Child provision to read as follows:

You must call Our office or send Us written notice of the birth of the child and We must receive any required additional premium within **90** days of birth **or the next premium due date, whichever is later.** (Emphasis added)

2. Pursuant to ACA 23-85-134, we have added the following statement to the first paragraph of the Termination Date of Coverage provision:

In the event of the Policyholder's death, We will refund within (30) thirty days after notice to Us, the unearned portion of any premium paid.

Accordingly, we have revised the page reference to 8079.EFF.AR.

Please also find attached an updated Outline of Coverage form 8079.OOC.AR. The only changes to this form are:

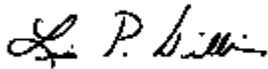
1. The policy form number reference on page 1 has been revised to reflect 8079.POL.AR; and
2. the exclusions section originally contained 22 exclusions and the policy only contains 21. That is because exclusion 20 should have been subitem h of exclusion 19. This was fixed in this revised version.

Accordingly, the form number was revised to 8079.OOC.AR.

We have attached an updated forms listing for this filing as well.

We trust that we have satisfactorily responded to your inquiry. Please do not hesitate to contact the undersigned at (215) 230-7960 if there are any additional questions I can answer regarding this filing.

Sincerely,

A handwritten signature in black ink, appearing to read "L. P. Williams".

Lisa P. Williams, FLMI  
Consultant  
McHugh Consulting Resources, Inc.



|         |  |
|---------|--|
| [00471] | [Diagnostic photographs]   |
| [00501] | [Histopathologic Examinations]   |
| [09310] | [Consultation (diagnostic service provided by Dentist or physician other than practitioner)] |
| [01110] | [Prophylaxis – adult]  |
| [01120] | [Prophylaxis – child]  |
| [01201] | [Topical application of fluoride (including prophylaxis) – child]                            |
| [01203] | [Topical application of fluoride (prophylaxis not included) – child]                         |
| [01204] | [Topical application of fluoride (prophylaxis not included) – adult]                         |
| [01205] | [Topical application of fluoride (including prophylaxis) – adult]                            |
| [01351] | [Sealant – per tooth]  |
| [01510] | [Space maintainer – fixed – unilateral]  |
| [01515] | [Space maintainer - fixed – bilateral]   |
| [01520] | [Space maintainer - removable – unilateral]  |
| [01525] | [Space maintainer - removable – bilateral]   |
| [01550] | [Re-cementation of space maintainer]]]   |

| <b>[Basic Dental Services Benefits:</b>   |  |                             |
|---|--|-----------------------------|
| [Benefits for all covered Basic Dental Services rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [\$100-50,000] [per Covered Person.]]                      |  |                             |
| [All benefits for covered Basic Dental Services are subject to the Basic and Major Services Combined Maximum Benefit Limitation shown on this Policy Schedule.]                                     |  |                             |
| [The Scheduled Benefits shown below will be reduced by [5-100]% for any covered procedure rendered during the first [[180-365] calendar days] [[1-2] Policy Year[s]] following the Effective Date.] |  |                             |
| <b>Procedure Code</b>   | <b>Basic Dental Services</b>   | <b>Scheduled Benefit</b>    |
| [09110]   | [Palliative (emergency) treatment of dental pain – minor procedure]                  | [\$15-100]                  |
| [09220]   | [Deep sedation/general anesthesia – first 30 minutes]                                | [\$50- <del>150</del> 300]  |
| [09221]   | [Deep sedation/general anesthesia-each additional 15 minutes]                        | [\$25-150]                  |
| [02140]   | [Amalgam – one surface, primary or permanent]  | [\$35-150]                  |
| [02150]   | [Amalgam – two surfaces – primary or permanent]                                      | [\$40-150]                  |
| [02160]   | [Amalgam – three surfaces – primary or permanent]                                    | [\$ <del>40</del> 40-150]   |
| [02161]   | [Amalgam – four or more surfaces, primary or permanent]                              | [\$ <del>45</del> 45-200]   |
| [02330]   | [Resin-based composite – one surface, anterior]                                      | [\$30-150]                  |
| [02331]   | [Resin-based composite – two surface, anterior]                                      | [\$35-150]                  |
| [02332]   | [Resin-based composite – three surfaces, anterior]                                   | [\$40-200]                  |
| [02335]   | [Resin-based composite – four or more surfaces or involving incisal angle(anterior)] | [\$45-200]                  |
| [02336]   | [Resin-based composite crown (anterior-primary)]                                     | [\$45-200]                  |
| [02391]   | [Resin-based composite – one surface, posterior – permanent or primary]              | [\$25-150]                  |
| [02392]   | [Resin-based composite – two surfaces, posterior – permanent or primary]             | [\$30-150]                  |
| [02393]   | [Resin-based composite – three surfaces, posterior – permanent or primary]           | [\$35-200]                  |
| [02394]   | [Resin-based composite – four or more surfaces, posterior]                           | [\$45- <del>200</del> 250]  |
| [02410]   | [Gold foil – one surface]  | [\$80-300]                  |
| [02420]   | [Gold foil – two surfaces]   | [\$100- <del>300</del> 400] |
| [07111]   | [Coronal re-cement – deciduous tooth]  | [\$15-100]                  |
| [07140]   | [Extraction, erupted tooth or exposed root (elevation and/or forceps removal)]       | [\$20-100]                  |
| [05410]   | [Adjust complete denture – maxillary]  | [\$15-100]                  |
| [05411]   | [Adjust complete denture – mandibular]   | [\$15-100]                  |
| [05421]   | [Adjust partial denture – maxillary]   | [\$15-100]                  |
| [05422]   | [Adjust partial denture – mandibular]  | [\$15-100]                  |

|         |  |                               |
|---------|--|-------------------------------|
| [05510] | [Repair broken complete denture base]                                | [\$50-<br><del>100</del> 150] |
| [05520] | [Replace missing or broken teeth – complete denture (each tooth)]    | [\$15-100]                    |
| [05610] | [Repair resin denture base]  | [\$20-<br><del>100</del> 150] |
| [05620] | [Repair cast framework]  | [\$20-<br><del>100</del> 200] |
| [05630] | [Repair or replace broken clasp]                                     | [\$25-150]                    |
| [05640] | [Replace broken teeth – per tooth]                                   | [\$15-100]                    |
| [05650] | [Add tooth to existing partial denture]                              | [\$30-<br><del>100</del> 150] |
| [05660] | [Add clasp to existing partial denture]                              | [\$25-150]                    |
| [05670] | [Replace all teeth and acrylic on case metal framework (maxillary)]  | [\$60-<br><del>250</del> 350] |
| [05671] | [Replace all teeth and acrylic on case metal framework (mandibular)] | [\$60-<br><del>250</del> 350] |
| [05710] | [Rebase complete maxillary denture]                                  | [\$60-<br><del>250</del> 350] |
| [05711] | [Rebase complete mandibular denture]                                 | [\$60-<br><del>250</del> 350] |
| [05720] | [Rebase maxillary partial denture]                                   | [\$60-<br><del>250</del> 350] |
| [05721] | [Rebase mandibular partial denture]                                  | [\$60-<br><del>250</del> 350] |
| [05730] | [Reline complete maxillary denture (chairside)]                      | [\$35-200]                    |
| [05731] | [Reline complete mandibular denture (chairside)]                     | [\$35-200]                    |
| [05740] | [Reline maxillary partial denture (chairside)]                       | [\$35-200]                    |
| [05741] | [Reline mandibular partial denture (chairside)]                      | [\$35-200]                    |
| [05750] | [Reline complete maxillary denture (laboratory)]                     | [\$50-<br><del>250</del> 350] |
| [05751] | [Reline complete mandibular denture (laboratory)]                    | [\$50-<br><del>250</del> 350] |
| [05760] | [Reline maxillary partial denture (laboratory)]                      | [\$45-<br><del>250</del> 350] |
| [05761] | [Reline mandibular partial denture (laboratory)]                     | [\$45-<br><del>250</del> 350] |
| [05850] | [Tissue conditioning, maxillary]                                     | [\$15-100]                    |
| [05851] | [Tissue conditioning, mandibular]                                    | [\$15-100]                    |
| [06930] | [Re-cement fixed partial denture]                                    | [\$20-150]                    |

|   |                                  |                           |
|---|----------------------------------|---------------------------|
| <b>[Major Dental Services Benefits:</b>   |                                  |                           |
| [Benefits for all covered Major Dental Services rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [\$100-50,000] [per Covered Person.]]  |                                  |                           |
| [All benefits for covered Major Dental Services are subject to the Basic and Major Services Combined Maximum Benefit Limitation shown on this Policy Schedule.]   |                                  |                           |
| [The Scheduled Benefits shown below will be reduced by [5-100]% for any covered procedure rendered during the first [[180-365] calendar day period][[1-2] Policy Year[s]] following the Effective Date. [The Scheduled Benefits shown below will be reduced by [5-100]% for any covered procedure rendered during the second [[180-365] calendar day period][Policy Year] following the Effective Date.]] |                                  |                           |
| <b>Procedure Code</b>   | <b>[Major Dental Services]</b>   | <b>Scheduled Benefits</b> |
| [02510]   | [Inlay – metallic – one surface] | [\$155-450]               |

|         |   |             |
|---------|---|-------------|
| [02520] | [Inlay – metallic – two surfaces]   | [\$180-500] |
| [02530] | [Inlay – metallic – three or more surfaces]   | [\$210-550] |
| [02543] | [Onlay – metallic – three surfaces]   | [\$210-550] |
| [02544] | [Onlay – metallic – four or more surfaces]  | [\$210-550] |
| [02610] | [Inlay – porcelain/ceramic – one surface]   | [\$180-450] |
| [02620] | [Inlay – porcelain/ceramic – two surfaces]  | [\$180-450] |
| [02630] | [Inlay – porcelain/ceramic – three or more surfaces]  | [\$210-550] |
| [02642] | [Onlay – porcelain/ceramic – two surfaces]  | [\$210-550] |
| [02643] | [Onlay – porcelain/ceramic – three surfaces]  | [\$210-550] |
| [02644] | [Onlay – porcelain/ceramic – four or more surfaces]   | [\$210-550] |
| [02650] | [Inlay – resin-based composite – one surface]   | [\$125-350] |
| [02651] | [Inlay – resin based composite – two surfaces]  | [\$130-400] |
| [02662] | [Onlay – resin based composite – two surfaces]  | [\$145-400] |
| [02663] | [Onlay – resin based composite – three surfaces]  | [\$155-450] |
| [02910] | [Re-cement inlay]   | [\$20-150]  |
| [02940] | [Sedative Filling]  | [\$20-150]  |
| [02951] | [Pin retention – per tooth, in addition to restoration]   | [\$10-100]  |
| [02710] | [Crown – resin laboratory]  | [\$80-350]  |
| [02720] | [Crown –resin with high noble metal]  | [\$180-650] |
| [02721] | [Crown – resin with predominantly base metal]   | [\$180-650] |
| [02722] | [Crown – resin with noble metal]  | [\$180-650] |
| [02740] | [Crown – porcelain/ceramic substrate]   | [\$180-650] |
| [02750] | [Crown – porcelain fused to high noble metal]   | [\$180-650] |
| [02751] | [Crown – porcelain fused to predominantly base metal]   | [\$180-650] |
| [02752] | [Crown – porcelain fused to noble metal]  | [\$180-650] |
| [02780] | [Crown – ¾ case high noble metal]   | [\$180-650] |
| [02781] | [Crown – ¾ case predominantly base metal]   | [\$180-650] |
| [02782] | [Crown – ¾ cast noble metal]  | [\$180-650] |
| [02790] | [Crown porcelain]   | [\$180-650] |
| [02791] | [Crown - full cast predominantly base metal]  | [\$180-650] |
| [02792] | [Crown – full cast noble metal]   | [\$180-650] |
| [02810] | [Crown – ¾ cast metallic]   | [\$180-650] |
| [02920] | [Re-cement crown]   | [\$20-150]  |
| [02930] | [Prefabricated stainless steel crown – primary tooth]   | [\$40-200]  |
| [02931] | [Prefabricated stainless steel crown – permanent tooth]   | [\$50-250]  |
| [02932] | [Prefabricated resin crown]   | [\$55-250]  |
| [02933] | [Prefabricated stainless steel crown with resin window]   | [\$60-250]  |
| [02940] | [Sedative filling]  | [\$20-150]  |
| [02950] | [Core buildup, including any pins]  | [\$40-200]  |
| [02952] | [Cast post and core in addition to crown]   | [\$60-250]  |
| [02954] | [Prefabricated post and core in addition to crown]  | [\$55-250]  |
| [02970] | [Temporary crown (fractured tooth)]   | [\$35-200]  |
| [03110] | [Pulp cap – direct (excluding final restoration)]   | [\$10-100]  |
| [03120] | [Pulp cap – indirect (excluding final restoration)]   | [\$10-100]  |
| [03220] | [Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medication] | [\$30-150]  |
| [03310] | [Anterior (excluding final restoration)]  | [\$120-350] |
| [03320] | [Bicuspid (excluding final restoration)]  | [\$150-450] |
| [03330] | [Molar (excluding final restoration)]   | [\$210-550] |
| [03346] | [Retreatment of previous root canal therapy – anterior]   | [\$120-350] |
| [03347] | [Retreatment of previous root canal therapy – bicuspid]   | [\$150-400] |
| [03348] | [Retreatment of previous root canal therapy – molar]  | [\$240-600] |
| [03410] | [Apicoectomy/periradicular surgery – anterior]  | [\$115-300] |

|         |  |             |
|---------|--|-------------|
| [03421] | [Apicoectomy/periradicular surgery – bicuspid (first root)]  | [\$155-500] |
| [03425] | [Apicoectomy/periradicular surgery – molar (first root)]   | [\$205-500] |
| [03426] | [Apicoectomy/periradicular surgery – (each additional root)]   | [\$60-250]  |
| [03430] | [Retrograde filling – per root]  | [\$40-200]  |
| [03450] | [Root amputation – per root]   | [\$85-350]  |
| [03920] | [Hemisection (including any root removal), not including root canal therapy]   | [\$65-250]  |
| [00180] | [Comprehensive periodontal evaluation – new or established patient]  | [\$10-100]  |
| [04210] | [Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant]                               | [\$110-300] |
| [04211] | [Gingivectomy or gingivoplasty – one to three teeth – per quadrant]  | [\$40-150]  |
| [04240] | [Gingival flap procedure, including root planning – four or more contiguous teeth or bounded teeth spaces per quadrant]            | [\$150-450] |
| [04249] | [Clinical crown lengthening – hard tissue]   | [\$215-450] |
| [04260] | [Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant]          | [\$205-500] |
| [04261] | [Osseous surgery (including flap entry and closure) – one to three teeth, per quadrant]  | [\$100-350] |
| [04263] | [Bone replacement graft – first site in quadrant]  | [\$60-250]  |
| [04264] | [Bone replacement graft – each additional site in quadrant]  | [\$30-150]  |
| [04270] | [Pedicle soft tissue graft procedure]  | [\$150-450] |
| [04271] | [Free soft tissue graft procedure (including donor site surgery)]  | [\$150-450] |
| [04341] | [Periodontal scaling and root planning – four or more contiguous teeth or bounded teeth spaces per quadrant]                       | [\$35-200]  |
| [04355] | [Full mouth debridement to enable comprehensive evaluation and diagnosis]  | [\$25-150]  |
| [04910] | [Periodontal maintenance]  | [\$25-150]  |
| [05110] | [Complete denture – maxillary]   | [\$190-550] |
| [05120] | [Complete denture – mandibular]  | [\$190-550] |
| [05130] | [Immediate denture – maxillary]  | [\$205-550] |
| [05140] | [Immediate denture – mandibular]   | [\$205-550] |
| [05211] | [Maxillary partial denture – resin base (including any conventional clasps, rests, and teeth)]                                     | [\$155-550] |
| [05212] | [Mandibular partial denture – resin base (including any conventional clasps, rests, and teeth)]                                    | [\$180-550] |
| [05213] | [Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)]  | [\$210-550] |
| [05214] | [Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)] | [\$210-550] |
| [05281] | [Removable unilateral partial denture – one piece cast metal (including clasps and teeth)]   | [\$120-450] |
| [06210] | [Pontic – cast high noble metal]   | [\$180-600] |
| [06211] | [Pontic – cast predominantly base metal]   | [\$180-600] |
| [06212] | [Pontic – cast noble metal]  | [\$180-600] |
| [06240] | [Pontic – porcelain fused to high noble metal]   | [\$180-600] |
| [06241] | [Pontic – porcelain fused to predominantly base metal]   | [\$180-600] |
| [06242] | [Pontic – porcelain fused to noble metal]  | [\$180-600] |
| [06250] | [Pontic – resin with high noble metal]   | [\$180-600] |
| [06251] | [Pontic – resin with predominantly base metal]   | [\$180-600] |
| [06252] | [Pontic – with noble metal]  | [\$180-600] |
| [06545] | [Retainer – cast metal for resin bonded fixed prosthesis]  | [\$70-300]  |
| [06602] | [Inlay – cast high noble metal, two surfaces]  | [\$180-600] |
| [06603] | [Inlay – cast high noble metal, three or more surfaces]  | [\$180-600] |
| [06604] | [Inlay – cast predominantly base metal, two surfaces]  | [\$180-600] |
| [06605] | [Inlay – cast predominantly base metal, three or more surfaces]  | [\$180-600] |
| [06606] | [Inlay – cast noble metal, two surfaces]   | [\$180-600] |
| [06607] | [Inlay – cast noble metal three or more surfaces]  | [\$180-600] |
| [06610] | [Onlay – cast high noble metal, two surfaces]  | [\$180-600] |

|         |   |              |
|---------|---|--------------|
| [06611] | [Onlay – cast high noble metal, three or more surfaces]   | [\$180-600]  |
| [06612] | [Onlay – cast predominantly base metal, two surfaces]   | [\$180-600]  |
| [06613] | [Onlay – cast predominantly base metal, three or more surfaces]   | [\$180-600]  |
| [06614] | [Onlay – cast noble metal, two surfaces]  | [\$180-600]  |
| [06615] | [Onlay – cast noble metal, three or more surfaces]  | [\$180-600]  |
| [06720] | [Crown – resin with high noble metal]   | [\$180-600]  |
| [06721] | [Crown – resin with predominantly base metal]   | [\$180-600]  |
| [06722] | [Crown – resin with noble metal]  | [\$180-600]  |
| [06740] | [Crown – porcelain/ceramic]   | [\$180-600]  |
| [06750] | [Crown – porcelain fused to high noble metal]   | [\$180-600]  |
| [06751] | [Crown – porcelain fused to predominantly base metal]   | [\$180-600]  |
| [06752] | [Crown – porcelain fused to noble metal]  | [\$180-600]  |
| [06780] | [Crown – ¾ cast high noble metal]   | [\$180-600]  |
| [06781] | [Crown – ¾ cast predominantly base metal]   | [\$180-600]  |
| [06782] | [Crown ¾ cast noble metal]  | [\$180-600]  |
| [06783] | [Crown ¾ cast porcelain/ceramic]  | [\$180-600]  |
| [06790] | [Crown – full cast high noble metal]  | [\$180-600]  |
| [06791] | [Crown – full cast predominantly base metal]  | [\$180-600]  |
| [06792] | [Crown – full cast noble metal]   | [\$180-600]  |
| [07210] | [Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth]  | [\$35-200]   |
| [07220] | [Removal of impacted tooth – soft tissue]   | [\$50-200]   |
| [07230] | [Removal of impacted tooth – partially bony]  | [\$65-300]   |
| [07240] | [Removal of impacted tooth – completely bony]   | [\$70-350]   |
| [07241] | [Removal of impacted tooth – completely bony, with unusual surgical complications]  | [\$95-350]   |
| [07250] | [Surgical removal of residual tooth roots (cutting procedure)]  | [\$40-250]   |
| [07260] | [Oroantral fistula closure]   | [\$330-1200] |
| [07270] | [Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth]  | [\$85-350]   |
| [07280] | [Surgical access of unerupted tooth]  | [\$90-350]   |
| [07281] | [Surgical exposure of impacted or unerupted tooth to aid eruption]  | [\$65-300]   |
| [07285] | [Biopsy of oral tissue – hard (bone, tooth)]  | [\$150-500]  |
| [07286] | [Biopsy of oral tissue – soft (all others)]   | [\$65-300]   |
| [07310] | [Alveoloplasty in conjunction with extractions – per quadrant]  | [\$40-200]   |
| [07320] | [Alveoloplasty not in conjunction with extractions – per quadrant]  | [\$170-600]  |
| [07340] | [Vestibuloplasty – ridge extension (secondary epithelialization)]   | [\$420-1100] |
| [07350] | [Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachments and management of hypertrophied tissue)] | [\$500-1200] |
| [07410] | [Excision of benign lesion up to 1.25 cm]   | [\$65-300]   |
| [07411] | [Excision of benign lesion greater than 1.25 cm]  | [\$240-750]  |
| [07413] | [Excision of malignant lesion up to 1.25 cm]  | [\$65-300]   |
| [07414] | [Excision of malignant lesion greater than 1.25 cm]   | [\$270-800]  |
| [07450] | [Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm.]  | [\$65-300]   |
| [07451] | [Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm]  | [\$240-700]  |
| [07460] | [Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm]  | [\$145-500]  |
| [07461] | [Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm]   | [\$240-750]  |
| [07471] | [Removal of lateral exostosis (maxilla or mandible)]  | [\$145-500]  |
| [07510] | [Incision and drainage of abscess – intraoral soft tissue]  | [\$40-200]   |
| [07520] | [Incision and drainage of abscess – extraoral soft tissue]  | [\$180-650]  |
| [07530] | [Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue]  | [\$65-300]   |
| [07540] | [Removal of reaction producing foreign bodies, musculoskeletal system]  | [\$80-350]   |
| [07550] | [Partial ostectomy/sequestrectomy for removal of non-vital bone]  | [\$50-250]   |
| [07560] | [Maxillary sinusotomy for removal of tooth fragment or foreign body]  | [\$480-1100] |
| [07960] | [Frenulectomy (frenectomy or frenotomy) - separate procedure]   | [\$90-350]   |

|         |  |             |
|---------|--|-------------|
| [07970] | [Excision of hyperplastic tissue – per arch] | [\$90-350]  |
| [07971] | [Excision of pericoronal gingival]           | [\$30-200]  |
| [07972] | [Surgical reduction of fibrous tuberosity]   | [\$115-400] |
| [07980] | [Sialodochoplasty]                           | [\$140-450] |

| <b>[Temporomandibular Joint Services Benefits:</b>   |   |                          |
|--|---|--------------------------|
| [Temporomandibular Joint Services Benefit Waiting Period: Temporomandibular Joint Services Benefits under this Policy are only payable for covered procedures rendered after[[180-365] calendar days] [1-3] Policy Year[s] from the Effective Date.]   |   |                          |
| [Benefits for all covered Temporomandibular Joint Services rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [\$100-50,000] [per Covered Person].]  |   |                          |
| [Benefits for all covered Temporomandibular Joint Services are limited to a maximum lifetime benefit of [\$100-50,000] [per Covered Person]. Once this maximum has been met, no additional Temporomandibular Joint Services Benefits are available [for that Covered Person] under this Policy.] |   |                          |
| [The Scheduled Benefits shown below will be reduced by [5-100]% for any covered procedure rendered during the first [ [1-3]Policy Year[s]] following the [Effective Date][end of the Benefit Waiting Period].]   |   |                          |
| <b>Procedure Code</b>  | <b>Temporomandibular Joint Services</b>                           | <b>Scheduled Benefit</b> |
| [00320]  | [Temporomandibular joint arthrogram, including injection]         | [\$130-450]              |
| [07610]  | [Maxilla – open reduction (teeth immobilized, if present)]        | [\$500-600]              |
| [07620]  | [Maxilla – closed reduction (teeth immobilized, if present)]      | [\$485-600]              |
| [07630]  | [Mandible - open reduction (teeth immobilized, if present)]       | [\$500-600]              |
| [07640]  | [Mandible - closed reduction (teeth immobilized, if present)]     | [\$500-600]              |
| [07650]  | [Malar and/or zygomatic arch – open reduction]                    | [\$400-600]              |
| [07660]  | [Malar and/or zygomatic arch – closed reduction]                  | [\$240-600]              |
| [07670]  | [Alveolus – closed reduction, may include stabilization of teeth] | [\$185-600]              |
| [07671]  | [Alveolus – open reduction, may include stabilization of teeth]   | [\$350-600]              |
| [07710]  | [Maxilla – open reduction]  | [\$500-600]              |
| [07720]  | [Maxilla – closed reduction]                                      | [\$500-600]              |
| [07730]  | [Mandible – open reduction]                                       | [\$500-600]              |
| [07740]  | [Mandible – closed reduction]                                     | [\$500-600]              |
| [07820]  | [Closed reduction of dislocation]                                 | [\$115-400]              |
| [07870]  | [Arthrocentesis]  | [\$50-200]               |
| [07880]  | [Occlusal orthotic device, by report]                             | [\$110-400]              |

|  |
|--|
| <b>[Orthodontic Benefits:</b>  |
| [Orthodontic Benefits are payable only after satisfaction of the Orthodontic Dental Services Benefit Waiting Period. The Orthodontic Dental Services Benefit Waiting Period is [1-3] Policy Year[s] following the Effective Date of coverage.]   |
| [Benefits for all covered Orthodontic Treatment rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [\$100-50,000] per Covered Person.] [Benefits for all covered Orthodontic Treatment rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [\$100-50,000] for all Covered Persons combined.]                      |
| [Benefits for all covered Orthodontic Treatment are limited to a maximum lifetime benefit of [\$100-50,000] [per Covered Person]. Once this maximum has been met, no additional Orthodontic Benefits are available [for that Covered Person] under this policy.]   |
| [We will pay [actual charges incurred] up to [\$200-600] for the initial Orthodontic Treatment consisting of one or more of the Orthodontic Dental Services listed below. Thereafter a fixed indemnity benefit of [\$200-600] is payable once [every three months] [every month] for continued Orthodontic Treatment involving one or more of the Orthodontic Dental Services listed below.] |

| <b>Procedure Code</b> | <b>Orthodontic Dental Services</b>  |
|-----------------------|---|
| [00340]               | [Cephalometric film]  |
| [00350]               | [Oral/facial images (includes intra and extraoral images)]                              |
| [00470]               | [Diagnostic casts]  |
| [08030]               | [Limited orthodontic treatment of adolescent dentition]                                 |
| [08080]               | [Comprehensive orthodontic treatment of the adolescent dentition]                       |
| [08210]               | [Removable appliance therapy]   |
| [08220]               | [Fixed appliance therapy]   |
| [08660]               | [Pre-orthodontic therapy]   |
| [08670]               | [Periodic orthodontic treatment visit (as part of contract)]                            |
| [08680]               | [Orthodontic retention (removal of appliance, construction and placement of retainers)] |

**[AGENT INFORMATION]**

[Name]

Address & Telephone Number]

SERFF Tracking Number: MCHX-126415671 State: Arkansas  
 Filing Company: Time Insurance Company State Tracking Number: 44308  
 Company Tracking Number: 8035.POL.AR  
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental  
 Product Name: 8079.POL.XX Individual Dental Indemnity Policy - T  
 Project Name/Number: 8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company /8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

| Creation Date: | Schedule            | Schedule Item Name                                | Replacement Creation Date | Attached Document(s)             |
|----------------|---------------------|---|---------------------------|----------------------------------|
| 01/26/2010     | Form                | Benefit Summary-Dental Insurance                  | 01/26/2010                | 8079_BNS_XX.PDF<br>(Superseded)  |
| 12/10/2009     | Form                | Dental Policy                                     | 12/23/2009                | 8079_POL_AR.PDF<br>(Superseded)  |
| 12/10/2009     | Form                | Benefit Summary-Dental Insurance                  | 01/26/2010                | 8079_BNS_XX.PDF<br>(Superseded)  |
| 12/10/2009     | Form                | Dental Policy-Effective Date and Termination Date | 12/23/2009                |                                  |
| 12/10/2009     | Form                | Outline of Coverage                               | 12/23/2009                | 8079_OOC_XX.PDF<br>(Superseded)  |
| 12/10/2009     | Supporting Document | Form Listing                                      | 12/23/2009                | Form Listing.PDF<br>(Superseded) |



|         |  |
|---------|--|
| [00471] | [Diagnostic photographs]   |
| [00501] | [Histopathologic Examinations]   |
| [09310] | [Consultation (diagnostic service provided by Dentist or physician other than practitioner)] |
| [01110] | [Prophylaxis – adult]  |
| [01120] | [Prophylaxis – child]  |
| [01201] | [Topical application of fluoride (including prophylaxis) – child]                            |
| [01203] | [Topical application of fluoride (prophylaxis not included) – child]                         |
| [01204] | [Topical application of fluoride (prophylaxis not included) – adult]                         |
| [01205] | [Topical application of fluoride (including prophylaxis) – adult]                            |
| [01351] | [Sealant – per tooth]  |
| [01510] | [Space maintainer – fixed – unilateral]  |
| [01515] | [Space maintainer - fixed – bilateral]   |
| [01520] | [Space maintainer - removable – unilateral]  |
| [01525] | [Space maintainer - removable – bilateral]   |
| [01550] | [Re-cementation of space maintainer]]]   |

| <b>[Basic Dental Services Benefits:</b>   |  |                          |
|---|--|--------------------------|
| [Benefits for all covered Basic Dental Services rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [\$100-50,000] [per Covered Person..]]                     |  |                          |
| [All benefits for covered Basic Dental Services are subject to the Basic and Major Services Combined Maximum Benefit Limitation shown on this Policy Schedule.]                                     |  |                          |
| [The Scheduled Benefits shown below will be reduced by [5-100]% for any covered procedure rendered during the first [[180-365] calendar days] [[1-2] Policy Year[s]] following the Effective Date.] |  |                          |
| <b>Procedure Code</b>   | <b>Basic Dental Services</b>   | <b>Scheduled Benefit</b> |
| [09110]   | [Palliative (emergency) treatment of dental pain – minor procedure]                  | [\$15-100]               |
| [09220]   | [Deep sedation/general anesthesia – first 30 minutes]                                | [\$50-300]               |
| [09221]   | [Deep sedation/general anesthesia-each additional 15 minutes]                        | [\$25-150]               |
| [02140]   | [Amalgam – one surface, primary or permanent]  | [\$35-150]               |
| [02150]   | [Amalgam – two surfaces – primary or permanent]                                      | [\$40-150]               |
| [02160]   | [Amalgam – three surfaces – primary or permanent]                                    | [\$40-150]               |
| [02161]   | [Amalgam – four or more surfaces, primary or permanent]                              | [\$45-200]               |
| [02330]   | [Resin-based composite – one surface, anterior]                                      | [\$30-150]               |
| [02331]   | [Resin-based composite – two surface, anterior]                                      | [\$35-150]               |
| [02332]   | [Resin-based composite – three surfaces, anterior]                                   | [\$40-200]               |
| [02335]   | [Resin-based composite – four or more surfaces or involving incisal angle(anterior)] | [\$45-200]               |
| [02336]   | [Resin-based composite crown (anterior-primary)]                                     | [\$45-200]               |
| [02391]   | [Resin-based composite – one surface, posterior – permanent or primary]              | [\$25-150]               |
| [02392]   | [Resin-based composite – two surfaces, posterior – permanent or primary]             | [\$30-150]               |
| [02393]   | [Resin-based composite – three surfaces, posterior – permanent or primary]           | [\$35-200]               |
| [02394]   | [Resin-based composite – four or more surfaces, posterior]                           | [\$45-250]               |
| [02410]   | [Gold foil – one surface]  | [\$80-300]               |
| [02420]   | [Gold foil – two surfaces]   | [\$100-400]              |
| [07111]   | [Coronal re-cement – deciduous tooth]  | [\$15-100]               |
| [07140]   | [Extraction, erupted tooth or exposed root (elevation and/or forceps removal)]       | [\$20-100]               |
| [05410]   | [Adjust complete denture – maxillary]  | [\$15-100]               |
| [05411]   | [Adjust complete denture – mandibular]   | [\$15-100]               |
| [05421]   | [Adjust partial denture – maxillary]   | [\$15-100]               |
| [05422]   | [Adjust partial denture – mandibular]  | [\$15-100]               |
| [05510]   | [Repair broken complete denture base]  | [\$50-150]               |
| [05520]   | [Replace missing or broken teeth – complete denture (each tooth)]                    | [\$15-100]               |
| [05610]   | [Repair resin denture base]  | [\$20-150]               |

|         |  |            |
|---------|--|------------|
| [05620] | [Repair cast framework]  | [\$20-200] |
| [05630] | [Repair or replace broken clasp]                                     | [\$25-150] |
| [05640] | [Replace broken teeth – per tooth]                                   | [\$15-100] |
| [05650] | [Add tooth to existing partial denture]                              | [\$30-150] |
| [05660] | [Add clasp to existing partial denture]                              | [\$25-150] |
| [05670] | [Replace all teeth and acrylic on case metal framework (maxillary)]  | [\$60-350] |
| [05671] | [Replace all teeth and acrylic on case metal framework (mandibular)] | [\$60-350] |
| [05710] | [Rebase complete maxillary denture]                                  | [\$60-350] |
| [05711] | [Rebase complete mandibular denture]                                 | [\$60-350] |
| [05720] | [Rebase maxillary partial denture]                                   | [\$60-350] |
| [05721] | [Rebase mandibular partial denture]                                  | [\$60-350] |
| [05730] | [Reline complete maxillary denture (chairside)]                      | [\$35-200] |
| [05731] | [Reline complete mandibular denture (chairside)]                     | [\$35-200] |
| [05740] | [Reline maxillary partial denture (chairside)]                       | [\$35-200] |
| [05741] | [Reline mandibular partial denture (chairside)]                      | [\$35-200] |
| [05750] | [Reline complete maxillary denture (laboratory)]                     | [\$50-350] |
| [05751] | [Reline complete mandibular denture (laboratory)]                    | [\$50-350] |
| [05760] | [Reline maxillary partial denture (laboratory)]                      | [\$45-350] |
| [05761] | [Reline mandibular partial denture (laboratory)]                     | [\$45-350] |
| [05850] | [Tissue conditioning, maxillary]                                     | [\$15-100] |
| [05851] | [Tissue conditioning, mandibular]                                    | [\$15-100] |
| [06930] | [Re-cement fixed partial denture]                                    | [\$20-150] |

| <b>[Major Dental Services Benefits:</b>   |   |                           |
|---|---|---------------------------|
| [Benefits for all covered Major Dental Services rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [\$100-50,000] [per Covered Person.]]  |   |                           |
| [All benefits for covered Major Dental Services are subject to the Basic and Major Services Combined Maximum Benefit Limitation shown on this Policy Schedule.]   |   |                           |
| [The Scheduled Benefits shown below will be reduced by [5-100]% for any covered procedure rendered during the first [[180-365] calendar day period][[1-2] Policy Year[s]] following the Effective Date. [The Scheduled Benefits shown below will be reduced by [5-100]% for any covered procedure rendered during the second [[180-365] calendar day period][Policy Year] following the Effective Date.]] |   |                           |
| <b>Procedure Code</b>   | <b>[Major Dental Services]</b>                          | <b>Scheduled Benefits</b> |
| [02510]   | [Inlay – metallic – one surface]                        | [\$155-450]               |
| [02520]   | [Inlay – metallic – two surfaces]                       | [\$180-500]               |
| [02530]   | [Inlay – metallic – three or more surfaces]             | [\$210-550]               |
| [02543]   | [Onlay – metallic – three surfaces]                     | [\$210-550]               |
| [02544]   | [Onlay – metallic – four or more surfaces]              | [\$210-550]               |
| [02610]   | [Inlay – porcelain/ceramic – one surface]               | [\$180-450]               |
| [02620]   | [Inlay – porcelain/ceramic – two surfaces]              | [\$180-450]               |
| [02630]   | [Inlay – porcelain/ceramic – three or more surfaces]    | [\$210-550]               |
| [02642]   | [Onlay – porcelain/ceramic – two surfaces]              | [\$210-550]               |
| [02643]   | [Onlay – porcelain/ceramic – three surfaces]            | [\$210-550]               |
| [02644]   | [Onlay – porcelain/ceramic – four or more surfaces]     | [\$210-550]               |
| [02650]   | [Inlay – resin-based composite – one surface]           | [\$125-350]               |
| [02651]   | [Inlay – resin based composite – two surfaces]          | [\$130-400]               |
| [02662]   | [Onlay – resin based composite – two surfaces]          | [\$145-400]               |
| [02663]   | [Onlay – resin based composite – three surfaces]        | [\$155-450]               |
| [02910]   | [Re-cement inlay]                                       | [\$20-150]                |
| [02940]   | [Sedative Filling]                                      | [\$20-150]                |
| [02951]   | [Pin retention – per tooth, in addition to restoration] | [\$10-100]                |

|         |   |             |
|---------|---|-------------|
| [02710] | [Crown – resin laboratory]  | [\$80-350]  |
| [02720] | [Crown –resin with high noble metal]  | [\$180-650] |
| [02721] | [Crown – resin with predominantly base metal]   | [\$180-650] |
| [02722] | [Crown – resin with noble metal]  | [\$180-650] |
| [02740] | [Crown – porcelain/ceramic substrate]   | [\$180-650] |
| [02750] | [Crown – porcelain fused to high noble metal]   | [\$180-650] |
| [02751] | [Crown – porcelain fused to predominantly base metal]   | [\$180-650] |
| [02752] | [Crown – porcelain fused to noble metal]  | [\$180-650] |
| [02780] | [Crown – ¾ case high noble metal]   | [\$180-650] |
| [02781] | [Crown – ¾ case predominantly base metal]   | [\$180-650] |
| [02782] | [Crown – ¾ cast noble metal]  | [\$180-650] |
| [02790] | [Crown porcelain]   | [\$180-650] |
| [02791] | [Crown - full cast predominantly base metal]  | [\$180-650] |
| [02792] | [Crown – full cast noble metal]   | [\$180-650] |
| [02810] | [Crown – ¾ cast metallic]   | [\$180-650] |
| [02920] | [Re-cement crown]   | [\$20-150]  |
| [02930] | [Prefabricated stainless steel crown – primary tooth]   | [\$40-200]  |
| [02931] | [Prefabricated stainless steel crown – permanent tooth]   | [\$50-250]  |
| [02932] | [Prefabricated resin crown]   | [\$55-250]  |
| [02933] | [Prefabricated stainless steel crown with resin window]   | [\$60-250]  |
| [02940] | [Sedative filling]  | [\$20-150]  |
| [02950] | [Core buildup, including any pins]  | [\$40-200]  |
| [02952] | [Cast post and core in addition to crown]   | [\$60-250]  |
| [02954] | [Prefabricated post and core in addition to crown]  | [\$55-250]  |
| [02970] | [Temporary crown (fractured tooth)]   | [\$35-200]  |
| [03110] | [Pulp cap – direct (excluding final restoration)]   | [\$10-100]  |
| [03120] | [Pulp cap – indirect (excluding final restoration)]   | [\$10-100]  |
| [03220] | [Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medication] | [\$30-150]  |
| [03310] | [Anterior (excluding final restoration)]  | [\$120-350] |
| [03320] | [Bicuspid (excluding final restoration)]  | [\$150-450] |
| [03330] | [Molar (excluding final restoration)]   | [\$210-550] |
| [03346] | [Retreatment of previous root canal therapy – anterior]   | [\$120-350] |
| [03347] | [Retreatment of previous root canal therapy – bicuspid]   | [\$150-400] |
| [03348] | [Retreatment of previous root canal therapy – molar]  | [\$240-600] |
| [03410] | [Apicoectomy/periradicular surgery – anterior]  | [\$115-300] |
| [03421] | [Apicoectomy/periradicular surgery – bicuspid (first root)]   | [\$155-500] |
| [03425] | [Apicoectomy/periradicular surgery – molar (first root)]  | [\$205-500] |
| [03426] | [Apicoectomy/periradicular surgery – (each additional root)]  | [\$60-250]  |
| [03430] | [Retrograde filling – per root]   | [\$40-200]  |
| [03450] | [Root amputation – per root]  | [\$85-350]  |
| [03920] | [Hemisection (including any root removal), not including root canal therapy]  | [\$65-250]  |
| [00180] | [Comprehensive periodontal evaluation – new or established patient]   | [\$10-100]  |
| [04210] | [Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant]  | [\$110-300] |
| [04211] | [Gingivectomy or gingivoplasty – one to three teeth – per quadrant]   | [\$40-150]  |
| [04240] | [Gingival flap procedure, including root planning – four or more contiguous teeth or bounded teeth spaces per quadrant]                       | [\$150-450] |
| [04249] | [Clinical crown lengthening – hard tissue]  | [\$215-450] |
| [04260] | [Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant]                     | [\$205-500] |
| [04261] | [Osseous surgery (including flap entry and closure) – one to three teeth, per quadrant]   | [\$100-350] |
| [04263] | [Bone replacement graft – first site in quadrant]   | [\$60-250]  |
| [04264] | [Bone replacement graft – each additional site in quadrant]   | [\$30-150]  |

|         |  |             |
|---------|--|-------------|
| [04270] | [Pedicle soft tissue graft procedure]  | [\$150-450] |
| [04271] | [Free soft tissue graft procedure (including donor site surgery)]  | [\$150-450] |
| [04341] | [Periodontal scaling and root planning – four or more contiguous teeth or bounded teeth spaces per quadrant]                       | [\$35-200]  |
| [04355] | [Full mouth debridement to enable comprehensive evaluation and diagnosis]  | [\$25-150]  |
| [04910] | [Periodontal maintenance]  | [\$25-150]  |
| [05110] | [Complete denture – maxillary]   | [\$190-550] |
| [05120] | [Complete denture – mandibular]  | [\$190-550] |
| [05130] | [Immediate denture – maxillary]  | [\$205-550] |
| [05140] | [Immediate denture – mandibular]   | [\$205-550] |
| [05211] | [Maxillary partial denture – resin base (including any conventional clasps, rests, and teeth)]                                     | [\$155-550] |
| [05212] | [Mandibular partial denture – resin base (including any conventional clasps, rests, and teeth)]                                    | [\$180-550] |
| [05213] | [Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)]  | [\$210-550] |
| [05214] | [Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)] | [\$210-550] |
| [05281] | [Removable unilateral partial denture – one piece cast metal (including clasps and teeth)]   | [\$120-450] |
| [06210] | [Pontic – cast high noble metal]   | [\$180-600] |
| [06211] | [Pontic – cast predominantly base metal]   | [\$180-600] |
| [06212] | [Pontic – cast noble metal]  | [\$180-600] |
| [06240] | [Pontic – porcelain fused to high noble metal]   | [\$180-600] |
| [06241] | [Pontic – porcelain fused to predominantly base metal]   | [\$180-600] |
| [06242] | [Pontic – porcelain fused to noble metal]  | [\$180-600] |
| [06250] | [Pontic – resin with high noble metal]   | [\$180-600] |
| [06251] | [Pontic – resin with predominantly base metal]   | [\$180-600] |
| [06252] | [Pontic – with noble metal]  | [\$180-600] |
| [06545] | [Retainer – cast metal for resin bonded fixed prosthesis]  | [\$70-300]  |
| [06602] | [Inlay – cast high noble metal, two surfaces]  | [\$180-600] |
| [06603] | [Inlay – cast high noble metal, three or more surfaces]  | [\$180-600] |
| [06604] | [Inlay – cast predominantly base metal, two surfaces]  | [\$180-600] |
| [06605] | [Inlay – cast predominantly base metal, three or more surfaces]  | [\$180-600] |
| [06606] | [Inlay – cast noble metal, two surfaces]   | [\$180-600] |
| [06607] | [Inlay – cast noble metal three or more surfaces]  | [\$180-600] |
| [06610] | [Onlay – cast high noble metal, two surfaces]  | [\$180-600] |
| [06611] | [Onlay – cast high noble metal, three or more surfaces]  | [\$180-600] |
| [06612] | [Onlay – cast predominantly base metal, two surfaces]  | [\$180-600] |
| [06613] | [Onlay – cast predominantly base metal, three or more surfaces]  | [\$180-600] |
| [06614] | [Onlay – cast noble metal, two surfaces]   | [\$180-600] |
| [06615] | [Onlay – cast noble metal, three or more surfaces]   | [\$180-600] |
| [06720] | [Crown – resin with high noble metal]  | [\$180-600] |
| [06721] | [Crown – resin with predominantly base metal]  | [\$180-600] |
| [06722] | [Crown – resin with noble metal]   | [\$180-600] |
| [06740] | [Crown – porcelain/ceramic]  | [\$180-600] |
| [06750] | [Crown – porcelain fused to high noble metal]  | [\$180-600] |
| [06751] | [Crown – porcelain fused to predominantly base metal]  | [\$180-600] |
| [06752] | [Crown – porcelain fused to noble metal]   | [\$180-600] |
| [06780] | [Crown – ¾ cast high noble metal]  | [\$180-600] |
| [06781] | [Crown – ¾ cast predominantly base metal]  | [\$180-600] |
| [06782] | [Crown ¾ cast noble metal]   | [\$180-600] |
| [06783] | [Crown ¾ cast porcelain/ceramic]   | [\$180-600] |
| [06790] | [Crown – full cast high noble metal]   | [\$180-600] |
| [06791] | [Crown – full cast predominantly base metal]   | [\$180-600] |

|         |   |              |
|---------|---|--------------|
| [06792] | [Crown – full cast noble metal]   | [\$180-600]  |
| [07210] | [Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth]  | [\$35-200]   |
| [07220] | [Removal of impacted tooth – soft tissue]   | [\$50-200]   |
| [07230] | [Removal of impacted tooth – partially bony]  | [\$65-300]   |
| [07240] | [Removal of impacted tooth – completely bony]   | [\$70-350]   |
| [07241] | [Removal of impacted tooth – completely bony, with unusual surgical complications]  | [\$95-350]   |
| [07250] | [Surgical removal of residual tooth roots (cutting procedure)]  | [\$40-250]   |
| [07260] | [Oroantral fistula closure]   | [\$330-1200] |
| [07270] | [Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth]  | [\$85-350]   |
| [07280] | [Surgical access of unerupted tooth]  | [\$90-350]   |
| [07281] | [Surgical exposure of impacted or unerupted tooth to aid eruption]  | [\$65-300]   |
| [07285] | [Biopsy of oral tissue – hard (bone, tooth)]  | [\$150-500]  |
| [07286] | [Biopsy of oral tissue – soft (all others)]   | [\$65-300]   |
| [07310] | [Alveoloplasty in conjunction with extractions – per quadrant]  | [\$40-200]   |
| [07320] | [Alveoloplasty not in conjunction with extractions – per quadrant]  | [\$170-600]  |
| [07340] | [Vestibuloplasty – ridge extension (secondary epithelialization)]   | [\$420-1100] |
| [07350] | [Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachments and management of hypertrophied tissue)] | [\$500-1200] |
| [07410] | [Excision of benign lesion up to 1.25 cm]   | [\$65-300]   |
| [07411] | [Excision of benign lesion greater than 1.25 cm]  | [\$240-750]  |
| [07413] | [Excision of malignant lesion up to 1.25 cm]  | [\$65-300]   |
| [07414] | [Excision of malignant lesion greater than 1.25 cm]   | [\$270-800]  |
| [07450] | [Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm.]  | [\$65-300]   |
| [07451] | [Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm]  | [\$240-700]  |
| [07460] | [Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm]  | [\$145-500]  |
| [07461] | [Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm]   | [\$240-750]  |
| [07471] | [Removal of lateral exostosis (maxilla or mandible)]  | [\$145-500]  |
| [07510] | [Incision and drainage of abscess – intraoral soft tissue]  | [\$40-200]   |
| [07520] | [Incision and drainage of abscess – extraoral soft tissue]  | [\$180-650]  |
| [07530] | [Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue]  | [\$65-300]   |
| [07540] | [Removal of reaction producing foreign bodies, musculoskeletal system]  | [\$80-350]   |
| [07550] | [Partial ostectomy/sequestrectomy for removal of non-vital bone]  | [\$50-250]   |
| [07560] | [Maxillary sinusotomy for removal of tooth fragment or foreign body]  | [\$480-1100] |
| [07960] | [Frenulectomy (frenectomy or frenotomy) - separate procedure]   | [\$90-350]   |
| [07970] | [Excision of hyperplastic tissue – per arch]  | [\$90-350]   |
| [07971] | [Excision of pericoronal gingival]  | [\$30-200]   |
| [07972] | [Surgical reduction of fibrous tuberosity]  | [\$115-400]  |
| [07980] | [Sialodochoplasty]  | [\$140-450]  |

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| <b>[Temporomandibular Joint Services Benefits:</b>   |
| [Temporomandibular Joint Services Benefit Waiting Period: Temporomandibular Joint Services Benefits under this Policy are only payable for covered procedures rendered after[[180-365] calendar days] [1-3] Policy Year[s] from the Effective Date.]   |
| [Benefits for all covered Temporomandibular Joint Services rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [\$100-50,000] [per Covered Person].]  |
| [Benefits for all covered Temporomandibular Joint Services are limited to a maximum lifetime benefit of [\$100-50,000] [per Covered Person]. Once this maximum has been met, no additional Temporomandibular Joint Services Benefits are available [for that Covered Person] under this Policy.] |
| [The Scheduled Benefits shown below will be reduced by [5-100]% for any covered procedure rendered during the first [ [1-3]Policy Year[s]] following the [Effective Date][end of the Benefit Waiting Period].]   |

| <b>Procedure Code</b> | <b>Temporomandibular Joint Services</b>                           | <b>Scheduled Benefit</b> |
|-----------------------|---|--------------------------|
| [00320]               | [Temporomandibular joint arthrogram, including injection]         | [\$130-450]              |
| [07610]               | [Maxilla – open reduction (teeth immobilized, if present)]        | [\$500-600]              |
| [07620]               | [Maxilla – closed reduction (teeth immobilized, if present)]      | [\$485-600]              |
| [07630]               | [Mandible - open reduction (teeth immobilized, if present)]       | [\$500-600]              |
| [07640]               | [Mandible - closed reduction (teeth immobilized, if present)]     | [\$500-600]              |
| [07650]               | [Malar and/or zygomatic arch – open reduction]                    | [\$400-600]              |
| [07660]               | [Malar and/or zygomatic arch – closed reduction]                  | [\$240-600]              |
| [07670]               | [Alveolus – closed reduction, may include stabilization of teeth] | [\$185-600]              |
| [07671]               | [Alveolus – open reduction, may include stabilization of teeth]   | [\$350-600]              |
| [07710]               | [Maxilla – open reduction]  | [\$500-600]              |
| [07720]               | [Maxilla – closed reduction]                                      | [\$500-600]              |
| [07730]               | [Mandible – open reduction]                                       | [\$500-600]              |
| [07740]               | [Mandible – closed reduction]                                     | [\$500-600]              |
| [07820]               | [Closed reduction of dislocation]                                 | [\$115-400]              |
| [07870]               | [Arthrocentesis]  | [\$50-200]               |
| [07880]               | [Occlusal orthotic device, by report]                             | [\$110-400]]             |

|  |   |
|--|---|
| <b>[Orthodontic Benefits:</b>  |   |
| [Orthodontic Benefits are payable only after satisfaction of the Orthodontic Dental Services Benefit Waiting Period. The Orthodontic Dental Services Benefit Waiting Period is [1-3] Policy Year[s] following the Effective Date of coverage.]   |   |
| [Benefits for all covered Orthodontic Treatment rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [\$100-50,000] per Covered Person.] [Benefits for all covered Orthodontic Treatment rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [\$100-50,000] for all Covered Persons combined.]                      |   |
| [Benefits for all covered Orthodontic Treatment are limited to a maximum lifetime benefit of [\$100-50,000] [per Covered Person]. Once this maximum has been met, no additional Orthodontic Benefits are available [for that Covered Person] under this policy.]   |   |
| [We will pay [actual charges incurred] up to [\$200-600] for the initial Orthodontic Treatment consisting of one or more of the Orthodontic Dental Services listed below. Thereafter a fixed indemnity benefit of \$[200-600] is payable once [every three months] [every month] for continued Orthodontic Treatment involving one or more of the Orthodontic Dental Services listed below.] |   |
| <b>Procedure Code</b>  | <b>Orthodontic Dental Services</b>  |
| [00340]  | [Cephalometric film]  |
| [00350]  | [Oral/facial images (includes intra and extraoral images)]                              |
| [00470]  | [Diagnostic casts]  |
| [08030]  | [Limited orthodontic treatment of adolescent dentition]                                 |
| [08080]  | [Comprehensive orthodontic treatment of the adolescent dentition]                       |
| [08210]  | [Removable appliance therapy]   |
| [08220]  | [Fixed appliance therapy]   |
| [08660]  | [Pre-orthodontic therapy]   |
| [08670]  | [Periodic orthodontic treatment visit (as part of contract)]                            |
| [08680]  | [Orthodontic retention (removal of appliance, construction and placement of retainers)] |

**[AGENT INFORMATION]**

[Name

Address & Telephone Number]

Time Insurance Company  
[501 West Michigan  
Milwaukee, WI 53203]

## DENTAL INDEMNITY INSURANCE POLICY

Limited Benefit Policy – This plan provides benefits for dental treatment only.

The insurance described in this Policy is effective on the date shown in the Policy Schedule only if You are eligible for the insurance, become insured, and remain insured subject to the terms, limits and conditions of this plan. This Policy is evidence of Your coverage. This Policy is issued and delivered in the [State] of Arkansas.

This Policy is issued based on the statements and agreements in the application/enrollment form and during the enrollment process, [any exam that may be required,] any other amendments or supplements and payment of the required premium. This Policy may be changed. If that happens, You will be notified of any such changes.

### RIGHT TO EXAMINE POLICY FOR [10-30] DAYS

If You are not satisfied, return the Policy to Us or Our agent within [10-30] days after You have received it. All premiums will be refunded and Your coverage will be void from the Effective Date.

### IMPORTANT NOTICE CONCERNING STATEMENTS IN YOUR APPLICATION/ENROLLMENT FORM FOR INSURANCE

Please read the copy of the application/enrollment form included with this Policy. We issued this coverage in reliance upon the accuracy and completeness of the information provided in the application/enrollment form and during the enrollment process. [If a material omission or misstatement is made in the application/enrollment form, We have the right to deny any claim, rescind the coverage and/or modify the terms of the coverage or the premium amount.] Carefully check the application/enrollment form and, if any information shown in the application/enrollment form is not correct and complete, write to Us at the address above, within 10 days.

[Secretary's Signature]  
Secretary

[President's Signature]  
President

[This Policy is guaranteed renewable until age [65-75] years. We may change premium for this Policy if We change premiums for all policies within the same class.]

This Policy automatically renews except for as stated in the  
Effective Date and Termination Date section.

Read Your Policy carefully to understand coverage limitations and termination provisions.

## GUIDE TO YOUR COVERAGE

The sections of the Policy appear in the following order:

- I Definitions
- II Dental Indemnity Insurance Benefits
- III Exclusions and Limitations
- IV Claim Provisions
- V Premium Provisions
- VI Effective Date and Termination Date
- VII Other Provisions

## I. Definitions

When reading this Policy, terms with a defined meaning will have the first letter of each word capitalized for easy identification. The capitalized terms used in this plan are defined below. Just because a term is defined does not mean it is covered. Please read the Policy carefully.

### Accident or Accidental

Any event that meets all of the following requirements:

[1.] it causes harm to the physical structure of the body.

[2.] it results from trauma.

[3.] it is the direct cause of a loss, independent of disease, dental infirmity or any other cause.

[4.] it is definite as to time and place.

[5.] it happens involuntarily, or entails unforeseen consequences if it is the result of an intentional act.

### [Basic Dental Services

Only those dental services specifically listed by procedure code on the Policy Schedule as Basic Dental Services.]

### Benefit Waiting Period

The period of time coverage must be in force before a Covered Person is eligible for payment of a particular type of benefit. Any applicable Benefit Waiting Period and its term will be shown on the Policy Schedule. Multiple Benefit Waiting Periods may apply [and run concurrently] under this plan.

### Calendar Year

The period beginning on January 1 of any year and ending on December 31 of the same year.

### Cosmetic Services

A surgery, procedure, injection, medication, or treatment primarily designed to improve appearance, self-esteem or body image and/or to relieve or prevent social, emotional or psychological distress.

### Covered Dependent

A person who meets the definition of a Dependent and is enrolled and eligible to receive benefits under this plan, as shown on the Policy Schedule.

### Covered Person

A person who is enrolled and eligible to receive benefits under this plan, as shown on the Policy Schedule.

### Dentally Necessary and Dental Necessity

Dental Treatment rendered to diagnose or treat a dental condition unless it is a Dental Preventive Services procedure as stated in the Policy Schedule. The Dental Treatment must be essential for the care of the teeth and supporting tissues. We must determine that such care:

- [1.] is appropriate and consistent with the diagnosis and does not exceed in scope, duration or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis and treatment of the dental condition; and
- [2.] is commonly accepted as proper care or treatment of the condition in accordance with United States dental standards and federal government guidelines; and
- [3.] can reasonably be expected to result in or contribute substantially to the improvements of a condition; and
- [4.] is provided [in the most conservative manner or] in the least intensive setting without adversely affecting the condition or the quality of dental care provided.

The fact that a Dental Hygienist, Dentist, or other dental care provider, facility or supplier may prescribe, order, recommend or approve a Dental Treatment does not, of itself, make the Dental Treatment Dentally Necessary for the purpose of determining eligibility under this Policy.

#### Dentist

A person licensed to practice dentistry by the state, or other geographic area [within the United States and its territories,] in which the covered procedure is rendered. The Dentist must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed.

#### Dental Hygienist

A person licensed as dental hygienist by the state, or other geographic area [within the United States and its territories,] in which the covered procedure is rendered. The Dental Hygienist must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed.

#### [Dental Preventive Services

Only those Dental Preventive Services specifically listed by procedure code on the Policy Schedule as Dental Preventive Services.]

#### Dependent

A Dependent is:

- [1.] the Policyholder's lawful spouse[, including the Policyholder's Domestic Partner if recognized under applicable law]; or
- [2.] the Policyholder's naturally born child, legally adopted child, a child that is placed for adoption with the Policyholder, a stepchild or a child for whom the Policyholder is the legal guardian:
  - [a.] [who is unmarried; and]
  - [b.] [who is age [18] or younger; and]
  - [c.] [who is claimed as an exemption on Your most recent federal income tax return, except for a Dependent child who is a full-time student.]

If Your unmarried child is age [19] or older, the child will be considered a Dependent if You give Us proof that:

- [1.] [the child is a full-time student at an accredited educational institution, college or university. A student will be considered full-time if the student meets the standards for full-time status at the school the student is attending. A student will be considered full-time during regular vacation periods that interrupt, but do not terminate, the continuous full-time course of study; or]
- [2.] [the child is not capable of self-sustaining employment or engaging in the normal and customary activities of a person of the same age because of mental incapacity or physical handicap. The child must also be chiefly dependent on the Policyholder for financial support and be claimed as an exemption on Your most recent federal income tax return. ]

A child will no longer be a Dependent on the earliest of the date that he or she:

- [1.] [is no longer a full-time student; or]
- [2.] [ceases to be claimed as an exemption on the Policyholder's federal income tax return, except for a Dependent child who is a full-time student; or]
- [3.] [attains age [24]; or]
- [4.] [marries; or]
- [5.] [is over age [18] and is capable of self-sustaining employment because he or she is no longer mentally incapacitated or physically handicapped.]

[If only Dependent children are covered under this plan, the youngest child will be considered the Policyholder. All siblings of the Policyholder will be considered Covered Dependents if they meet the requirements above.]

#### [Domestic Partner

A person of the same or opposite gender who resides with the Policyholder in a long-term relationship of indefinite duration. The partners have an exclusive mutual commitment to be jointly responsible for each others common welfare and share financial obligations. The Domestic Partner must meet all of the following requirements:

- [1.] be at least [18] years of age.
- [2.] be competent to enter into a contract.
- [3.] not be related by blood to a degree of closeness that would prohibit legal marriage in the state in which he or she legally resides.

A Domestic Partner must provide Us with [an affidavit attesting that the domestic partnership has existed for a minimum period of [24 months]] [evidence of state registry or license of the civil union/partnership] at the time of enrollment under this plan. [Proof that the Domestic Partner relationship continues to exist will be requested by Us periodically.]

#### Effective Date

The date coverage under this plan begins for a Covered Person as stated on the Policy Schedule. The Covered Person's coverage begins at 12:01 a.m. local time in the state of issuance on the Effective Date approved by Us.

#### Emergency Dental Treatment

Any Dentally Necessary service, procedure, or supply which is rendered as the direct result of unforeseen events or circumstances which require prompt attention.

[Experimental or Investigational Services Treatment, services, supplies or equipment which, at the time the treatment is rendered, We determine are:

- [1.] not proven to be of benefit for diagnosis or treatment of the dental condition; or
- [2.] not generally used or recognized by the medical or dental community as safe, effective and appropriate for diagnosis or treatment; or
- [3.] in the research or investigational stage, provided or performed in a special setting for research purposes or under a controlled environment or clinical protocol; or
- [4.] obsolete or ineffective for the treatment; or
- [5.] medications used for non-FDA approved indications and/or dosage regimens.]

#### Family Plan

A plan of insurance covering the Policyholder and one or more of the Policyholder's dependents as shown on the Policy Schedule.

#### Functioning Natural Tooth (Teeth)

A healthy tooth with normal function in the mastication process in the upper or lower arch and that is opposed in the other arch by another tooth or prosthetic replacement. For purposes of this Policy, third molars are not considered Functioning Natural Teeth.

#### Home Office

Our office in [Milwaukee, Wisconsin] or other administrative offices as indicated by Us.

#### Immediate Family Member

An Immediate Family Member is:

- [1.] You or Your spouse; or
- [2.] the children, brothers, sisters and parents of either You or Your spouse; or
- [3.] the spouses of the children, brothers and sisters of You and Your spouse; or
- [4.] anyone with whom a Policyholder has a relationship based on a legal guardianship.

#### Injury

Accidental bodily damage, independent of all other causes, occurring unexpectedly and unintentionally.

[Major Dental Services

Only those dental services specifically listed by procedure code on the Policy Schedule as Major Dental Services.]

[Orthodontic Dental Services

Only those orthodontic services specifically listed by procedure code on the Policy Schedule as Orthodontic Dental Services.]

[Orthodontic Treatment

The corrective movement of teeth through the bone by means of an active appliance to correct a handicapping Malocclusion (a Malocclusion severely interfering with a person's ability to chew food) of the mouth by use of Orthodontic Dental Services. [We will make the determination of the severity of the Malocclusion.]]

Policy

The contract issued by Us to the Policyholder for benefit of Covered Persons.

Policyholder

The person listed on the Policy Schedule as the Policyholder.

[Policy Year

The period beginning on the month and day of the Effective Date in any year and ending on the same month and day as the Effective Date in the following year.]

Sickness

A disease or illness of a Covered Person. Sickness does not include a family history of a disease or illness or a genetic predisposition for the development of a future disease or illness.

Single Plan

A plan of insurance covering only the Policyholder as shown in the Policy Schedule.

We, Us, Our, Our Company

Time Insurance Company or its administrator.

You, Your, Yours

The person listed on the Policy Schedule as the Policyholder.

## II. Dental Indemnity Insurance Benefits

WE WILL PAY BENEFITS ONLY FOR THE SERVICES AND SUPPLIES LISTED AS DENTAL BENEFITS IN THIS SECTION OF THE PLAN. HOW BENEFITS ARE PAID AND THE MAXIMUM BENEFIT FOR THE COVERED SERVICES AND SUPPLIES LISTED IN THIS SECTION ARE SHOWN IN THE POLICY SCHEDULE.

REFER TO THE EXCLUSIONS SECTION FOR SERVICES AND SUPPLIES THAT ARE NOT COVERED UNDER THIS POLICY.

[Benefits paid under this section are subject to any maximum benefit limitation provided under this plan. Benefits are subject to all the terms, limits and conditions in this plan.]

[We will not pay benefits for Dental Treatment rendered during a Covered Person's Benefit Waiting Period. A Benefit Waiting Period only applies if it is shown in the Policy Schedule. [Benefits are available from the first day Covered Charges are incurred for a Dental Injury that is sustained on or after the Covered Person's Effective Date.]]

We pay only for Dental Treatment, according to the following classifications and subject to the benefit amounts provided on the Policy Schedule, when Dentally Necessary and provided by a Dentist or Dental Hygienist licensed to perform such procedure or treatment:

### [Dental Preventive Benefits

We will pay the benefit shown on the Policy Schedule for Dental Preventive Services. All preventive visits must be separated by at least [90-270] calendar days for benefits to be payable. The benefit amount is paid only once regardless of the number of Dental Preventive Services provided during any one visit. [To be eligible for benefits, Dental Preventive Services must be rendered by a licensed Dentist or Dental Hygienist.]]

### [Basic Dental Services Benefits

We will pay the Scheduled Benefit for Basic Dental Services as show on the Policy Schedule. [The Scheduled Benefit will be reduced by [5-100]% for all Basic Dental Services rendered during the first [[180-365] calendar days] [1-2] [Policy Year][s] following the Effective Date of coverage. Thereafter the full Scheduled Benefit will be paid for covered Basic Dental Services.] [All benefits for Basic Dental Services rendered during the same Calendar Year are subject to the maximum Calendar Year benefit for Basic Dental Services shown on the Policy Schedule.] [All benefits for covered Basic Dental Services are subject to the Basic and Major Services Combined Maximum Benefit Limitation shown on the Policy Schedule.]]

### [Major Dental Services Benefits

We will pay the Scheduled Benefit for Major Dental Services as show on the Policy Schedule. [The Scheduled Benefit will be reduced by [5-100]% for all Major Dental Services rendered during the first [[180-365] calendar days] [1-3][Policy Year][s] following the Effective Date of coverage. [The Scheduled Benefit will be reduced by [5-100]% for all Major Dental Services rendered during the second [[180-365] calendar days] [1-3] [Policy Year][s] following the Effective Date of coverage.] Thereafter the full Scheduled Benefit will be paid for covered Major Dental Services.] [All benefits for Major Dental Services rendered during the same Calendar Year are subject to the maximum Calendar Year benefit for Major Dental Services shown on the Policy Schedule.] [All benefits for covered Major Dental Services are subject to the Basic and Major Services Combined Maximum Benefit Limitation shown on the Policy Schedule.]]

[Temporomandibular Joint Services Benefits

We will pay the Scheduled Benefit for Temporomandibular Joint Services as show on the Policy Schedule. [A Benefit Waiting Period of [[180-365] calendar days] [1-3] [Policy Year][s] applies for each Covered Person.] [The Scheduled Benefit will be reduced by [5-100]% for all Temporomandibular Joint Services rendered during the first [1-3] [Policy Year][s] following the [Effective Date of coverage][end of the Benefit Waiting Period].] [Thereafter the full Scheduled Benefit will be paid for covered Temporomandibular Joint Services.] [All benefits for Temporomandibular Joint Services rendered during the same Calendar Year are subject to the maximum Calendar Year benefit for Temporomandibular Joint Services shown on the Policy Schedule.] [All benefits for Temporomandibular Joint Services are subject to the maximum lifetime benefit for Temporomandibular Joint Services shown on the Policy Schedule, per Covered Person.]]

[Orthodontic Benefits

[Orthodontic Benefits are payable only after satisfaction of the Orthodontic Dental Services Benefit Waiting Period. The Orthodontic Dental Services Benefit Waiting Period is [1-3] Policy Year[s] following the Effective Date of coverage.]

[Only Covered Persons who are under age [18] years are eligible for Orthodontic Benefits. Orthodontic Treatment must have been initiated prior to the Covered Person's [17<sup>th</sup>] birthday. Benefits for Orthodontic Treatment cease upon attainment of the Covered Person's [18<sup>th</sup>] birthday.]

Benefits for Orthodontic Treatment are not payable for expenses incurred for retention of orthodontic relationships. Benefits for Orthodontic Treatment are payable only for active Orthodontic Treatment for the Orthodontic Dental Services listed on the Policy Schedule.

[We will pay benefits for Orthodontic Treatment involving Orthodontic Dental Services listed on the Policy Schedule when the treatment begins while the Covered Person is insured under the plan. No payment will be made for the Orthodontic Treatment if the appliances or bands are inserted prior to becoming insured. We consider Orthodontic Treatment to be started on the date the bands or appliances are inserted. Any other Orthodontic Treatment that can be completed on the same day it is rendered is considered to be started and completed on the date the Orthodontic Treatment is rendered.]

We will pay the benefit amount shown in the Policy Schedule after any required Benefit Waiting Period has been satisfied. The maximum benefit payable to a Covered Person is shown in the Policy Schedule. The maximum benefit will apply even if coverage is interrupted.

[We will make a payment for covered orthodontic services related to the initial Orthodontic Treatment, which consists of diagnosis, evaluation, pre-care and insertion of bands or appliances. After the payment for the initial Orthodontic Treatment, benefits for covered Orthodontic Dental Services will be paid in equal [monthly] [quarterly] payments over the course of the remaining Orthodontic Treatment. The initial Orthodontic Treatment and [quarterly] [monthly] indemnity benefit amounts are shown on the Policy Schedule.]]

### III. Exclusions and Limitations

#### Limited Benefits

This Policy pays limited, fixed indemnity benefits for Dental Treatments only. See the Policy Schedule for the limited benefit amounts and maximum benefit limitations.

#### Exclusions

[We will not pay benefits for any of the following:

- [1.] [any procedure or treatment not shown on the Policy Schedule.]
- [2.] [any procedure rendered during an applicable Benefit Waiting Period.]
- [3.] [any amount in excess of a Calendar Year or Lifetime maximum benefit limitation.]
- [4.] [Dental Preventive Benefits when there is less than [90-270] calendar days between the dates of service for Dental Preventive Services.]
- [5.] [all Experimental or Investigative Services.]
- [6.] [any procedure performed by a person other than a Dentist or Dental Hygienist.]
- [7.] [any procedure performed by a Covered Person's Immediate Family Member.]
- [8.] [all services that are not Dentally Necessary.]
- [9.] [repairs to dental work less than [30-180] calendar days following completion of the initial procedure.]
- [10.] [prosthetics replaced less than [2-20] years following the previous placement.]
- [11.] [crowns replaced less than [2-20] years following the previous placement.]
- [12.] [inlays or onlays replaced less than [2-20] years following the last placement.]
- [13.] [dental implants or the removal of implants.]
- [14.] [Cosmetic Services, unless performed to correct a functional disorder.]
- [15.] [services performed outside the United States [and][,] [its territories] [and Canada] except for services that are received for Emergency Dental Treatment.]
- [16.] [replacement of any tooth missing prior to the Effective Date.]
- [17.] [placement of full or partial dentures, whether removable or fixed, including a Maryland Bridge, unless replacing a Functioning Natural Tooth extracted after the Effective Date[and not within a Benefit Waiting Period].]

- [18.] [for Covered Persons under age 16, inlays, onlays, bridgework or crowns except for stainless steel or plastic crowns.]
- [19.] [any charge or procedure for treatment required because of Dental Injury or disease due to:
- [a.] [war or any act of war, whether declared or undeclared.]
  - [b.] [participation in the military service of any country or international organization[,including non-military units supporting such forces.]]
  - [c.] [charges for Sickness or Injury caused or aggravated by attempted suicide or self-inflicted Sickness or Injury, even if the Covered Person did not intend to cause the harm which resulted from the action which led to the self-inflicted Sickness or Injury.]
  - [d.] [taking part in a riot or insurrection, or an act of riot or insurrection.]
  - [e.] [participating in, voluntarily attempting to commit or commission of a felony, whether or not charged, or engaging in an illegal occupation or activity at the time of an Accident.]
  - [f.] [voluntary use of any controlled substance, as defined by statute, except when administered in accordance with the advice of the Covered Person's health care practitioner.]
  - [g.] [riding in any aircraft not licensed to carry passengers or not operated by a duly licensed pilot.]
  - [h.] [charges for treatment or services required due to an Injury sustained in operating a motor vehicle while the Covered Person's blood alcohol level, as defined by law, was [.08] or higher. This exclusion applies whether or not the Covered Person is charged with any violation in connection with the Accident.]
- [20.] [procedures rendered before the Effective Date or after the termination date of coverage.]
- [21.] [orthodontic treatment and services]

[In addition to the Exclusions listed above, the following exclusion applies to Orthodontic Dental Services coverage:

We will not pay benefits for Orthodontic Treatment procedures rendered after the Covered Person's [18<sup>th</sup> birthday.]

## IV. Claim Provisions

### Proof of Loss

Most providers will file claims directly with Us. You are responsible for filing a claim with Us if the provider does not file it. The following provisions tell You how to file claims with Us.

We must receive written or electronic notice of the services that were received for which the claim is made. Notice must be provided to Us within [90 days] after a covered loss occurs or as soon as reasonably possible. Unless You are declared incompetent by a court of law, written or electronic proof of loss must be sent to Us within [12-15 months] of the date of loss.

The proof of loss must include all of the following:

- [1.] Your name and Policy number.
- [2.] the name of the Covered Person who incurred the claim.
- [3.] the name[, national provider identifier (NPI)] and address of the provider of the services.
- [4.] an itemized bill from the provider of the services that includes the Dental Treatment performed in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature or by narrative description.

When We receive written or electronic proof of loss, We may require additional information. You must furnish all items We decide are necessary to determine Our liability in accordance with the Right to Collect Information provision in this section. We will not pay benefits if the required information or authorization for its release is not furnished to Us. We reserve the right to request X-rays, narratives and other diagnostic information, as We see fit, to determine benefits.

### Right to Collect Information

To determine Our liability, We may request additional information from a Covered Person, Dentist, Dental Hygienist, facility, or other individual or entity. A Covered Person must cooperate with Us, and assist Us by obtaining the following information within [30-90 days] of Our request. Charges will be denied if We are unable to determine Our liability because a Covered Person, Dentist, Dental Hygienist, facility, or other individual or entity failed to:

- [1.] authorize the release of all medical and dental records to Us and other information We requested.
- [2.] provide Us with information We requested about pending claims.
- [3.] provide Us with information that is accurate and complete.
- [4.] have any examination completed as requested by Us.
- [5.] provide reasonable cooperation to any requests made by Us.

Such charges may be considered for benefits upon receipt of the requested information, provided all necessary information is received prior to expiration of the time allowed for submission of claim information as set forth in this Claim Provisions section.

#### Physical Examination

We have the right to have a provider of Our choice examine a Covered Person at any time regarding a claim for benefits. These exams will be paid by Us.

#### Payment of Benefits

Benefits will be paid when We receive due written or electronic proof of loss, subject to any time period requirements under state law. Benefits for services provided will be paid to the Policyholder unless they have been assigned to a provider. Any benefits unpaid at Your death will be paid at Our option to Your spouse, [Your Domestic Partner,] Your estate or the providers of the services.

We will pay dental claims when coded according to the [American Dental Association Uniform Code on Dental Procedures and Nomenclature] [or] [Current Dental Terminology (CDT) manual]. We will not pay for: charges that are billed separately as professional services when the procedure requires only a technical component; or charges that are billed incorrectly or billed separately but are an integral part of another billed service, as determined by Us; or other claims that are improperly billed; or duplicates of previously received or processed claims.

Any amount We pay in good faith will release Us from further liability for that amount. Payment by Us does not constitute any assumption of liability for further coverage under this plan.

#### Overpayment

If a benefit is paid under this plan and it is later shown that a lesser amount should have been paid, We will be entitled to recover the excess amount from You or the person or entity receiving the incorrect payment. [We may offset any overpayment to You or a provider against future benefit payments.]

#### Rights of Administration

We maintain Our ability to determine Our rights and obligations under this plan including, without limitation, the eligibility for and amount of any benefits payable.

#### Claims Involving Misrepresentation or Fraud

Claims will be denied in whole or in part in the event of misrepresentation or fraud by a Covered Person or a Covered Person's representative. If benefits are paid under this plan and it is later shown the claims for these benefits involved misrepresentation or fraud, We will be entitled to a refund from You or the person or entity receiving the payment.

A claim will not be honored if the Covered Person or the provider of the charges will not, or cannot, provide adequate documentation to substantiate that treatment was rendered for the claim submitted. If the Covered Person, or anyone acting on the Covered Person's behalf, knowingly files a fraudulent claim, claims may be denied in whole or in part, coverage may be terminated or rescinded, and the Covered Person may be subject to civil and/or criminal penalties.

#### Workers' Compensation Not Affected

Insurance under this plan does not replace or affect any requirements for coverage by workers' compensation insurance. If state law allows, We may participate in a workers' compensation dispute arising from a claim for which We paid benefits.

#### Claim Appeal

You have the right to request a review of all adverse claim decisions. A review must be requested in writing within [180-365 days] following Your receipt of the notice that the claim was denied or reduced.

## V. Premium Provisions

### Consideration

This plan is issued based on the statements and agreements in the Covered Person's application/enrollment form and during the enrollment process, any exam of a Covered Person that is required, any other amendments or supplements to the application/enrollment form and payment of the required premium. Each renewal premium is payable on the due date subject to the Grace Period provision in this section.

### Premium Payment

The initial premium must be paid on or before the due date for this coverage to be in force. Subsequent premiums are due as billed by Us. Each renewal premium must be received by Us on its due date subject to the Grace Period provision in this section. Premiums must be received in cash or check at Our office on the date due. [We may agree to accept premium payment in alternative forms, such as credit card [or automatic charge to a bank account].] [We reserve the right to dishonor any such agreement for payment of premium during the grace period if We tried to obtain payment for the amount due using the alternative method but were unsuccessful.]

Your premium may be adjusted from time to time based on different factors including, but not limited to, Your geographic area, [gender,] [age,] payment method and plan design. All premium adjustments will be made to individuals on the basis of shared characteristics. The premium may also change if You add or delete Covered Dependents, change the payment method, move to another zip code or otherwise change the coverage. [The mode of payment (monthly, quarterly or other) is subject to change. You will be notified at least 60 days in advance of any such change.]

### Grace Period

There is a grace period of [31 days] for the payment of each premium due after the initial premium. If the full premium due is not received at Our Home Office by the end of the grace period, the coverage will end on the date that the grace period ends. [If any claims become payable during the grace period, any unpaid premium due will be deducted from the claim payment.] If the premium is received during or by the end of the grace period, coverage will continue without interruption unless You call Our office or give Us written notice to cancel the coverage.

### [Reinstatement

If any premium is not paid within the required time period, coverage for You and any Covered Dependents will lapse. The coverage will be reinstated only if all of the following requirements are met:

- [1.] the lapse was not more than [30-180] days.
- [2.] You submit an application/enrollment form for reinstatement to Us along with the required premium payment. Submission of premium to Your agent is not submission of premium to Us. [We may require payment of unpaid premium during the lapsed period, but not to any period prior to the date occurring 60 days before the reinstatement date].
- [3.] We approve Your application/enrollment form for reinstatement.

The coverage will be reinstated on the date We approve Your application/enrollment form for reinstatement. If We have not responded to Your application/enrollment form for reinstatement by the 45th day after We receive the application/enrollment form, the coverage will be reinstated on that date. If the

coverage is reinstated, the loss resulting from an Injury will only be covered only if the Injury is sustained on or after the date of reinstatement. Benefits under the Policy will not be paid for dental Sickness or conditions diagnosed between the lapse date and the tenth day following the date of reinstatement.

In all other respects, You and Our Company will have the same rights as existed under this plan before the coverage lapsed, subject to any provisions included with or attached to this plan in connection with the reinstatement.]

[Covered Dependent Conversion

A Covered Dependent may be eligible to convert to another similar dental plan that We issue in the Covered Dependent's state of residence at the time coverage terminates under this plan if:

- [1.] the Covered Dependent's insurance terminates due to a valid decree of divorce between the Policyholder and the Covered Dependent; or
- [2.] the Covered Dependent's insurance terminates due to the death of the Policyholder; or
- [3.] a Covered Dependent child's insurance terminates because the child no longer meets the eligibility requirements for a Dependent.

To obtain conversion coverage, the Covered Dependent must submit a written application/enrollment form and the required premium to Us within [31 days] after coverage under this plan terminates. Evidence of insurability will not be required. Coverage will be provided on the dental insurance form that We offer for providing conversion coverage at that time. However, the conversion plan may provide different benefit levels, covered services and premium rates.

If written enrollment is not made within [31-60 days] following the termination of insurance under this plan, conversion coverage may not be available.

The conversion coverage will take effect at 12:01 a.m. local time at the covered person's residence on the day after coverage under this plan terminates. Benefits paid under the new plan cannot exceed any applicable maximum benefit that would have otherwise been paid under the terms of this Policy if coverage under this Policy would have remained in force.]

## VI. Effective Date and Termination Date

### Eligibility and Effective Date of Policyholder

A person who is eligible may elect to be covered under this plan by completing the enrollment process and submitting any required premium. [You must be a resident of the state where this plan is issued.] [Evidence of insurability must also be provided.] Your coverage will take effect at 12:01 a.m. local time in the state of issuance on the Effective Date approved by Us.

[If the Policyholder moves to a different state after the Effective Date, We will replace this Policy with a similar plan that is issued in the Policyholder's new state of residence. Coverage under the new plan will be effective on the date the Policyholder becomes a resident of the new state. If the Policyholder moves to a state where We do not provide insurance coverage under a plan similar to this Policy, We reserve the right to terminate this coverage for You and any Covered Dependents.]

### Eligibility and Effective Date of Dependents

The following information explains how You can obtain coverage for any Dependents that You want to add to Your plan. [If the Policyholder has a Single Plan on the Effective Date of his or her plan, a Dependent cannot be added after the Policyholder's Effective Date.] [If this is a Family Plan, a] [A] Dependent can be added after the Policyholder's Effective Date. To be covered under this plan, a person must meet the Dependent definition in this plan and is subject to the additional requirements below:

- [1.] Adding a Newborn Child: You must call Our office or send Us written notice of the birth of the child and We must receive any required additional premium within 60 days of birth. The Effective Date of coverage will be 12:01 a.m. local time at the Policyholder's state of residence on the date the child is born. [If this is a Single Plan and these requirements are not met, the child will not be covered from birth. However, if this is a Family Plan and if][If] these requirements are not met, Your newborn child will be covered only for the first 31 days from birth.
- [2.] Adding an Adopted Child or Child Placed for Adoption: A newly adopted child can be added on the date the child is placed with the Policyholder in anticipation of legal adoption and the Policyholder assumes a legal obligation for support of the child. You must call Our office or send Us written notice of the placement for adoption of the child and We must receive any required additional premium within 60 days of the placement for adoption. The Effective Date of coverage will be 12:01 a.m. local time at the Policyholder's state of residence on the date the child is placed for adoption. [If this is a Single Plan and these requirements are not met, the child will not be covered from date of placement. However, if this is a Family Plan and if][If] these requirements are not met, Your newly adopted child will be covered for only for the first 31 days from the earlier of adoption or placement for adoption. A child is no longer considered adopted if, prior to legal adoption, You relinquish legal obligation for support of the child and the child is removed from placement.
- [3.] Adding Any Other Dependent: To add any other Dependent, an application/enrollment form must be completed and sent to Us along with any required premium. Evidence of insurability must also be provided. The Effective Date of coverage will be 12:01 a.m. local time in the state of issuance on the Effective Date approved by Us.

### Termination Date of Coverage

The Policyholder may cancel this coverage at any time by sending Us written notice or calling Our office. Upon cancellation, We will return the unearned portion of any premium paid, in accordance with the laws in the Policyholder's state of residence.

This coverage will terminate at 12:01 a.m. local time at the Policyholder's state of residence on the earliest of the following dates:

- [1.] the date We receive a request in writing or by telephone to terminate this plan or on a later date that is requested by the Policyholder for termination.
- [2.] the date We receive a request in writing or by telephone to terminate coverage for a Covered Dependent or on a later date that is requested by the Policyholder for termination of a Covered Dependent.
- [3.] the date this plan lapses for nonpayment of premium per the Grace Period provision in the Premium Provisions section.
- [4.] [the date there is fraud or material misrepresentation made by or with the knowledge of any Covered Person [applying for this coverage or] filing a claim for benefits.]
- [5.] [the date all policies with the same form number as this Policy are non-renewed in the state in which this Policy was issued or the state in which the Policyholder presently resides.]
- [6.] [the date We terminate or non-renew [health][dental] insurance coverage in the individual market in the state in which this Policy was issued or the state in which You presently reside. We will give You advance notice, as required by state law, of the termination of Your coverage.]
- [7.] [[on][t]he date the Policyholder moves to a state where We do not provide insurance coverage under the same plan as this Policy[, We reserve the right to terminate this coverage].]
- [8.] [for a Covered Dependent: on the date a Covered Dependent no longer meets the Dependent definition in this plan.]
- [9.] [the date the Policyholder attains age [65-75] years.] [The anniversary date of this Policy following the Policyholder's [65<sup>th</sup> – 75<sup>th</sup>] birthday.]

## VII. Other Provisions

### Assignment [Prohibited]

A Covered Person's right to benefits under this Policy is [not] assignable. [A signed copy of the assignment must be sent to Our Home Office in a form acceptable to Us. The assignment is subject to any payment made or other action taken before We receive the assignment.]

### Modification of Policy or Coverage

The Policy may be changed at any time. We will give You [30-90] days notice prior to any change. No change in the Policy will be valid unless approved by one of Our executive officers and included with this Policy. No agent or other employee of Our Company has authority to waive or change any plan provision or waive any other applicable enrollment or application requirements.

We may modify the insurance coverage for You and any Covered Dependents. This modification will be consistent with state law and will apply uniformly to all policies in the state of issue with Your plan of coverage. You will be notified of any change.

### Clerical Error

If a clerical error is made by Us, it will not affect the insurance to which a Covered Person is entitled. Delay or failure to report termination of any insurance will not continue the insurance in force beyond the date it would have terminated according to this Policy. The premium charges will be adjusted as required, but not for more than [two years] prior to the date the error was found. If the premium was overpaid, We will refund the difference. If the premium was underpaid, the difference must be paid to Us within [60-180 days] of Our notifying You of the error.

### Conformity with State Statutes

If this plan, on its Effective Date, is in conflict with any applicable federal laws or laws of the state where it is issued, it is changed to meet the minimum requirements of those laws. In the event that new or applicable state or federal laws are enacted which conflict with current provisions of this plan, the provisions that are affected will be administered in accordance with the new applicable laws, despite anything in the plan to the contrary.

### Enforcement of Plan Provisions

Failure by Us to enforce or require compliance with any provision within this plan will not waive, modify or render any provision unenforceable at any other time, whether the circumstances are the same or not.

### Entire Contract

This Policy is issued to the Policyholder. The entire contract of insurance includes the Policy, a Covered Person's application/enrollment form, and any riders and endorsements. A copy of the application/enrollment form shall be included when the Policy is issued.

### Representations

In the absence of fraud, all statements made on the application/enrollment form will be deemed representations and not warranties. This provision does not preclude defenses based upon provisions relating to eligibility. No statement made in the application/enrollment form will be used in any suit or action at law or equity unless a copy of the application/enrollment form is furnished to the Policyholder, or

in the event of death or incapacity of the Policyholder, a copy will be furnished to the Policyholder's beneficiary or personal representative.

#### [Incentives, Rebates and Contributions

[We may elect to furnish [or participate in programs with other organizations that furnish] [group applicants for coverage] [members of groups applying for coverage][individual applicants for coverage][Covered Persons] [individuals] [that meet common criteria or requirements determined by Us] [not to include health, dental or claims history] with "premium holidays" or programs where premiums, fees, plan benefit limits will be discounted, credited, refunded, waived or otherwise adjusted [or] [where other gifts or items of value may be offered or provided to You at no charge or a discount] [at a time or times] [or] [for a period] determined by Us.]]

#### Misstatements

If a Covered Person's material information has been misstated and the premium amount would have been different had the correct information been disclosed, an adjustment in premiums may be made based on the corrected information. In addition to adjusting future premiums, We may require payment of past premiums at the adjusted rate to continue coverage. If the Covered Person's age is misstated and coverage would not have been issued based on the Covered Person's true age, Our sole liability will be to refund all of the premiums paid for that Covered Person's coverage, minus the amount of any benefits paid by Us.

#### Incontestability and Time Limit on Certain Defenses

Within the first three years after the Effective Date of coverage, We have the right to rescind or modify Your Policy of insurance coverage and/or deny a claim for a Covered Person if the application/enrollment form contains an omission or misrepresentation, whether intended or not, which We determine to be material. We also reserve the right to rescind a Policy of insurance and/or deny a claim for a fraudulent misstatement or omission at any time during the coverage period.

#### Legal Action and Forum

No suit or action at law or in equity may be brought to recover benefits under this plan until expiration of 60 days after Proof of Loss has been furnished in accordance with the requirements of this Policy. No suit or action at law or in equity can be brought later than 3 years from the date loss is incurred. Any lawsuits or disputes arising under the terms of the Policy must be brought in the United States District Court for the Eastern District of Wisconsin.



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|---------|--|
| [00471] | [Diagnostic photographs]   |
| [00501] | [Histopathologic Examinations]   |
| [09310] | [Consultation (diagnostic service provided by Dentist or physician other than practitioner)] |
| [01110] | [Prophylaxis – adult]  |
| [01120] | [Prophylaxis – child]  |
| [01201] | [Topical application of fluoride (including prophylaxis) – child]                            |
| [01203] | [Topical application of fluoride (prophylaxis not included) – child]                         |
| [01204] | [Topical application of fluoride (prophylaxis not included) – adult]                         |
| [01205] | [Topical application of fluoride (including prophylaxis) – adult]                            |
| [01351] | [Sealant – per tooth]  |
| [01510] | [Space maintainer – fixed – unilateral]  |
| [01515] | [Space maintainer - fixed – bilateral]   |
| [01520] | [Space maintainer - removable – unilateral]  |
| [01525] | [Space maintainer - removable – bilateral]   |
| [01550] | [Re-cementation of space maintainer]]]   |

| <b>[Basic Dental Services Benefits:</b>   |  |                          |
|---|--|--------------------------|
| [Benefits for all covered Basic Dental Services rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [\$100-50,000] [per Covered Person.]]                      |  |                          |
| [All benefits for covered Basic Dental Services are subject to the Basic and Major Services Combined Maximum Benefit Limitation shown on this Policy Schedule.]                                     |  |                          |
| [The Scheduled Benefits shown below will be reduced by [5-100]% for any covered procedure rendered during the first [[180-365] calendar days] [[1-2] Policy Year[s]] following the Effective Date.] |  |                          |
| <b>Procedure Code</b>   | <b>Basic Dental Services</b>   | <b>Scheduled Benefit</b> |
| [09110]   | [Palliative (emergency) treatment of dental pain – minor procedure]                  | [\$15-100]               |
| [09220]   | [Deep sedation/general anesthesia – first 30 minutes]                                | [\$50-150]               |
| [09221]   | [Deep sedation/general anesthesia-each additional 15 minutes]                        | [\$25-150]               |
| [02140]   | [Amalgam – one surface, primary or permanent]  | [\$35-150]               |
| [02150]   | [Amalgam – two surfaces – primary or permanent]                                      | [\$40-150]               |
| [02160]   | [Amalgam – three surfaces – primary or permanent]                                    | [\$\$40-150]             |
| [02161]   | [Amalgam – four or more surfaces, primary or permanent]                              | [\$\$45-200]             |
| [02330]   | [Resin-based composite – one surface, anterior]                                      | [\$30-150]               |
| [02331]   | [Resin-based composite – two surface, anterior]                                      | [\$35-150]               |
| [02332]   | [Resin-based composite – three surfaces, anterior]                                   | [\$40-200]               |
| [02335]   | [Resin-based composite – four or more surfaces or involving incisal angle(anterior)] | [\$45-200]               |
| [02336]   | [Resin-based composite crown (anterior-primary)]                                     | [\$45-200]               |
| [02391]   | [Resin-based composite – one surface, posterior – permanent or primary]              | [\$25-150]               |
| [02392]   | [Resin-based composite – two surfaces, posterior – permanent or primary]             | [\$30-150]               |
| [02393]   | [Resin-based composite – three surfaces, posterior – permanent or primary]           | [\$35-200]               |
| [02394]   | [Resin-based composite – four or more surfaces, posterior]                           | [\$45-200]               |
| [02410]   | [Gold foil – one surface]  | [\$80-300]               |
| [02420]   | [Gold foil – two surfaces]   | [\$100-300]              |
| [07111]   | [Coronal re-cement – deciduous tooth]  | [\$15-100]               |
| [07140]   | [Extraction, erupted tooth or exposed root (elevation and/or forceps removal)]       | [\$20-100]               |
| [05410]   | [Adjust complete denture – maxillary]  | [\$15-100]               |
| [05411]   | [Adjust complete denture – mandibular]   | [\$15-100]               |
| [05421]   | [Adjust partial denture – maxillary]   | [\$15-100]               |
| [05422]   | [Adjust partial denture – mandibular]  | [\$15-100]               |
| [05510]   | [Repair broken complete denture base]  | [\$50-100]               |
| [05520]   | [Replace missing or broken teeth – complete denture (each tooth)]                    | [\$15-100]               |
| [05610]   | [Repair resin denture base]  | [\$20-100]               |

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|---------|--|------------|
| [05620] | [Repair cast framework]  | [\$20-100] |
| [05630] | [Repair or replace broken clasp]                                     | [\$25-150] |
| [05640] | [Replace broken teeth – per tooth]                                   | [\$15-100] |
| [05650] | [Add tooth to existing partial denture]                              | [\$30-100] |
| [05660] | [Add clasp to existing partial denture]                              | [\$25-150] |
| [05670] | [Replace all teeth and acrylic on case metal framework (maxillary)]  | [\$60-250] |
| [05671] | [Replace all teeth and acrylic on case metal framework (mandibular)] | [\$60-250] |
| [05710] | [Rebase complete maxillary denture]                                  | [\$60-250] |
| [05711] | [Rebase complete mandibular denture]                                 | [\$60-250] |
| [05720] | [Rebase maxillary partial denture]                                   | [\$60-250] |
| [05721] | [Rebase mandibular partial denture]                                  | [\$60-250] |
| [05730] | [Reline complete maxillary denture (chairside)]                      | [\$35-200] |
| [05731] | [Reline complete mandibular denture (chairside)]                     | [\$35-200] |
| [05740] | [Reline maxillary partial denture (chairside)]                       | [\$35-200] |
| [05741] | [Reline mandibular partial denture (chairside)]                      | [\$35-200] |
| [05750] | [Reline complete maxillary denture (laboratory)]                     | [\$50-250] |
| [05751] | [Reline complete mandibular denture (laboratory)]                    | [\$50-250] |
| [05760] | [Reline maxillary partial denture (laboratory)]                      | [\$45-250] |
| [05761] | [Reline mandibular partial denture (laboratory)]                     | [\$45-250] |
| [05850] | [Tissue conditioning, maxillary]                                     | [\$15-100] |
| [05851] | [Tissue conditioning, mandibular]                                    | [\$15-100] |
| [06930] | [Re-cement fixed partial denture]                                    | [\$20-150] |

| <b>[Major Dental Services Benefits:</b>   |   |                           |
|---|---|---------------------------|
| [Benefits for all covered Major Dental Services rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [\$100-50,000] [per Covered Person.]]  |   |                           |
| [All benefits for covered Major Dental Services are subject to the Basic and Major Services Combined Maximum Benefit Limitation shown on this Policy Schedule.]   |   |                           |
| [The Scheduled Benefits shown below will be reduced by [5-100]% for any covered procedure rendered during the first [[180-365] calendar day period][[1-2] Policy Year[s]] following the Effective Date. [The Scheduled Benefits shown below will be reduced by [5-100]% for any covered procedure rendered during the second [[180-365] calendar day period][Policy Year] following the Effective Date.]] |   |                           |
| <b>Procedure Code</b>   | <b>[Major Dental Services]</b>                          | <b>Scheduled Benefits</b> |
| [02510]   | [Inlay – metallic – one surface]                        | [\$155-450]               |
| [02520]   | [Inlay – metallic – two surfaces]                       | [\$180-500]               |
| [02530]   | [Inlay – metallic – three or more surfaces]             | [\$210-550]               |
| [02543]   | [Onlay – metallic – three surfaces]                     | [\$210-550]               |
| [02544]   | [Onlay – metallic – four or more surfaces]              | [\$210-550]               |
| [02610]   | [Inlay – porcelain/ceramic – one surface]               | [\$180-450]               |
| [02620]   | [Inlay – porcelain/ceramic – two surfaces]              | [\$180-450]               |
| [02630]   | [Inlay – porcelain/ceramic – three or more surfaces]    | [\$210-550]               |
| [02642]   | [Onlay – porcelain/ceramic – two surfaces]              | [\$210-550]               |
| [02643]   | [Onlay – porcelain/ceramic – three surfaces]            | [\$210-550]               |
| [02644]   | [Onlay – porcelain/ceramic – four or more surfaces]     | [\$210-550]               |
| [02650]   | [Inlay – resin-based composite – one surface]           | [\$125-350]               |
| [02651]   | [Inlay – resin based composite – two surfaces]          | [\$130-400]               |
| [02662]   | [Onlay – resin based composite – two surfaces]          | [\$145-400]               |
| [02663]   | [Onlay – resin based composite – three surfaces]        | [\$155-450]               |
| [02910]   | [Re-cement inlay]                                       | [\$20-150]                |
| [02940]   | [Sedative Filling]                                      | [\$20-150]                |
| [02951]   | [Pin retention – per tooth, in addition to restoration] | [\$10-100]                |

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|---------|---|-------------|
| [02710] | [Crown – resin laboratory]  | [\$80-350]  |
| [02720] | [Crown –resin with high noble metal]  | [\$180-650] |
| [02721] | [Crown – resin with predominantly base metal]   | [\$180-650] |
| [02722] | [Crown – resin with noble metal]  | [\$180-650] |
| [02740] | [Crown – porcelain/ceramic substrate]   | [\$180-650] |
| [02750] | [Crown – porcelain fused to high noble metal]   | [\$180-650] |
| [02751] | [Crown – porcelain fused to predominantly base metal]   | [\$180-650] |
| [02752] | [Crown – porcelain fused to noble metal]  | [\$180-650] |
| [02780] | [Crown – ¾ case high noble metal]   | [\$180-650] |
| [02781] | [Crown – ¾ case predominantly base metal]   | [\$180-650] |
| [02782] | [Crown – ¾ cast noble metal]  | [\$180-650] |
| [02790] | [Crown porcelain]   | [\$180-650] |
| [02791] | [Crown - full cast predominantly base metal]  | [\$180-650] |
| [02792] | [Crown – full cast noble metal]   | [\$180-650] |
| [02810] | [Crown – ¾ cast metallic]   | [\$180-650] |
| [02920] | [Re-cement crown]   | [\$20-150]  |
| [02930] | [Prefabricated stainless steel crown – primary tooth]   | [\$40-200]  |
| [02931] | [Prefabricated stainless steel crown – permanent tooth]   | [\$50-250]  |
| [02932] | [Prefabricated resin crown]   | [\$55-250]  |
| [02933] | [Prefabricated stainless steel crown with resin window]   | [\$60-250]  |
| [02940] | [Sedative filling]  | [\$20-150]  |
| [02950] | [Core buildup, including any pins]  | [\$40-200]  |
| [02952] | [Cast post and core in addition to crown]   | [\$60-250]  |
| [02954] | [Prefabricated post and core in addition to crown]  | [\$55-250]  |
| [02970] | [Temporary crown (fractured tooth)]   | [\$35-200]  |
| [03110] | [Pulp cap – direct (excluding final restoration)]   | [\$10-100]  |
| [03120] | [Pulp cap – indirect (excluding final restoration)]   | [\$10-100]  |
| [03220] | [Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medication] | [\$30-150]  |
| [03310] | [Anterior (excluding final restoration)]  | [\$120-350] |
| [03320] | [Bicuspid (excluding final restoration)]  | [\$150-450] |
| [03330] | [Molar (excluding final restoration)]   | [\$210-550] |
| [03346] | [Retreatment of previous root canal therapy – anterior]   | [\$120-350] |
| [03347] | [Retreatment of previous root canal therapy – bicuspid]   | [\$150-400] |
| [03348] | [Retreatment of previous root canal therapy – molar]  | [\$240-600] |
| [03410] | [Apicoectomy/periradicular surgery – anterior]  | [\$115-300] |
| [03421] | [Apicoectomy/periradicular surgery – bicuspid (first root)]   | [\$155-500] |
| [03425] | [Apicoectomy/periradicular surgery – molar (first root)]  | [\$205-500] |
| [03426] | [Apicoectomy/periradicular surgery – (each additional root)]  | [\$60-250]  |
| [03430] | [Retrograde filling – per root]   | [\$40-200]  |
| [03450] | [Root amputation – per root]  | [\$85-350]  |
| [03920] | [Hemisection (including any root removal), not including root canal therapy]  | [\$65-250]  |
| [00180] | [Comprehensive periodontal evaluation – new or established patient]   | [\$10-100]  |
| [04210] | [Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant]  | [\$110-300] |
| [04211] | [Gingivectomy or gingivoplasty – one to three teeth – per quadrant]   | [\$40-150]  |
| [04240] | [Gingival flap procedure, including root planning – four or more contiguous teeth or bounded teeth spaces per quadrant]                       | [\$150-450] |
| [04249] | [Clinical crown lengthening – hard tissue]  | [\$215-450] |
| [04260] | [Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant]                     | [\$205-500] |
| [04261] | [Osseous surgery (including flap entry and closure) – one to three teeth, per quadrant]   | [\$100-350] |
| [04263] | [Bone replacement graft – first site in quadrant]   | [\$60-250]  |
| [04264] | [Bone replacement graft – each additional site in quadrant]   | [\$30-150]  |

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| [04270] | [Pedicle soft tissue graft procedure]  | [\$150-450] |
| [04271] | [Free soft tissue graft procedure (including donor site surgery)]  | [\$150-450] |
| [04341] | [Periodontal scaling and root planning – four or more contiguous teeth or bounded teeth spaces per quadrant]                       | [\$35-200]  |
| [04355] | [Full mouth debridement to enable comprehensive evaluation and diagnosis]  | [\$25-150]  |
| [04910] | [Periodontal maintenance]  | [\$25-150]  |
| [05110] | [Complete denture – maxillary]   | [\$190-550] |
| [05120] | [Complete denture – mandibular]  | [\$190-550] |
| [05130] | [Immediate denture – maxillary]  | [\$205-550] |
| [05140] | [Immediate denture – mandibular]   | [\$205-550] |
| [05211] | [Maxillary partial denture – resin base (including any conventional clasps, rests, and teeth)]                                     | [\$155-550] |
| [05212] | [Mandibular partial denture – resin base (including any conventional clasps, rests, and teeth)]                                    | [\$180-550] |
| [05213] | [Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)]  | [\$210-550] |
| [05214] | [Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)] | [\$210-550] |
| [05281] | [Removable unilateral partial denture – one piece cast metal (including clasps and teeth)]   | [\$120-450] |
| [06210] | [Pontic – cast high noble metal]   | [\$180-600] |
| [06211] | [Pontic – cast predominantly base metal]   | [\$180-600] |
| [06212] | [Pontic – cast noble metal]  | [\$180-600] |
| [06240] | [Pontic – porcelain fused to high noble metal]   | [\$180-600] |
| [06241] | [Pontic – porcelain fused to predominantly base metal]   | [\$180-600] |
| [06242] | [Pontic – porcelain fused to noble metal]  | [\$180-600] |
| [06250] | [Pontic – resin with high noble metal]   | [\$180-600] |
| [06251] | [Pontic – resin with predominantly base metal]   | [\$180-600] |
| [06252] | [Pontic – with noble metal]  | [\$180-600] |
| [06545] | [Retainer – cast metal for resin bonded fixed prosthesis]  | [\$70-300]  |
| [06602] | [Inlay – cast high noble metal, two surfaces]  | [\$180-600] |
| [06603] | [Inlay – cast high noble metal, three or more surfaces]  | [\$180-600] |
| [06604] | [Inlay – cast predominantly base metal, two surfaces]  | [\$180-600] |
| [06605] | [Inlay – cast predominantly base metal, three or more surfaces]  | [\$180-600] |
| [06606] | [Inlay – cast noble metal, two surfaces]   | [\$180-600] |
| [06607] | [Inlay – cast noble metal three or more surfaces]  | [\$180-600] |
| [06610] | [Onlay – cast high noble metal, two surfaces]  | [\$180-600] |
| [06611] | [Onlay – cast high noble metal, three or more surfaces]  | [\$180-600] |
| [06612] | [Onlay – cast predominantly base metal, two surfaces]  | [\$180-600] |
| [06613] | [Onlay – cast predominantly base metal, three or more surfaces]  | [\$180-600] |
| [06614] | [Onlay – cast noble metal, two surfaces]   | [\$180-600] |
| [06615] | [Onlay – cast noble metal, three or more surfaces]   | [\$180-600] |
| [06720] | [Crown – resin with high noble metal]  | [\$180-600] |
| [06721] | [Crown – resin with predominantly base metal]  | [\$180-600] |
| [06722] | [Crown – resin with noble metal]   | [\$180-600] |
| [06740] | [Crown – porcelain/ceramic]  | [\$180-600] |
| [06750] | [Crown – porcelain fused to high noble metal]  | [\$180-600] |
| [06751] | [Crown – porcelain fused to predominantly base metal]  | [\$180-600] |
| [06752] | [Crown – porcelain fused to noble metal]   | [\$180-600] |
| [06780] | [Crown – ¾ cast high noble metal]  | [\$180-600] |
| [06781] | [Crown – ¾ cast predominantly base metal]  | [\$180-600] |
| [06782] | [Crown ¾ cast noble metal]   | [\$180-600] |
| [06783] | [Crown ¾ cast porcelain/ceramic]   | [\$180-600] |
| [06790] | [Crown – full cast high noble metal]   | [\$180-600] |
| [06791] | [Crown – full cast predominantly base metal]   | [\$180-600] |

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| [06792] | [Crown – full cast noble metal]   | [\$180-600]  |
| [07210] | [Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth]  | [\$35-200]   |
| [07220] | [Removal of impacted tooth – soft tissue]   | [\$50-200]   |
| [07230] | [Removal of impacted tooth – partially bony]  | [\$65-300]   |
| [07240] | [Removal of impacted tooth – completely bony]   | [\$70-350]   |
| [07241] | [Removal of impacted tooth – completely bony, with unusual surgical complications]  | [\$95-350]   |
| 07250]  | [Surgical removal of residual tooth roots (cutting procedure)]  | [\$40-250]   |
| [07260] | [Oroantral fistula closure]   | [\$330-1200] |
| [07270] | [Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth]  | [\$85-350]   |
| [07280] | [Surgical access of unerupted tooth]  | [\$90-350]   |
| [07281] | [Surgical exposure of impacted or unerupted tooth to aid eruption]  | [\$65-300]   |
| [07285] | [Biopsy of oral tissue – hard (bone, tooth)]  | [\$150-500]  |
| [07286] | [Biopsy of oral tissue – soft (all others)]   | [\$65-300]   |
| [07310] | [Alveoloplasty in conjunction with extractions – per quadrant]  | [\$40-200]   |
| [07320] | [Alveoloplasty not in conjunction with extractions – per quadrant]  | [\$170-600]  |
| [07340] | [Vestibuloplasty – ridge extension (secondary epithelialization)]   | [\$420-1100] |
| [07350] | [Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachments and management of hypertrophied tissue)] | [\$500-1200] |
| [07410] | [Excision of benign lesion up to 1.25 cm]   | [\$65-300]   |
| [07411] | [Excision of benign lesion greater than 1.25 cm]  | [\$240-750]  |
| [07413] | [Excision of malignant lesion up to 1.25 cm]  | [\$65-300]   |
| [07414] | [Excision of malignant lesion greater than 1.25 cm]   | [\$270-800]  |
| [07450] | [Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm.]  | [\$65-300]   |
| [07451] | [Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm]  | [\$240-700]  |
| [07460] | [Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm]  | [\$145-500]  |

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| [07461] | [Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm] | [\$240-750]  |
| [07471] | [Removal of lateral exostosis (maxilla or mandible)]                                    | [\$145-500]  |
| [07510] | [Incision and drainage of abscess – intraoral soft tissue]                              | [\$40-200]   |
| [07520] | [Incision and drainage of abscess – extraoral soft tissue]                              | [\$180-650]  |
| [07530] | [Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue]            | [\$65-300]   |
| [07540] | [Removal of reaction producing foreign bodies, musculoskeletal system]                  | [\$80-350]   |
| [07550] | [Partial ostectomy/sequestrectomy for removal of non-vital bone]                        | [\$50-250]   |
| [07560] | [Maxillary sinusotomy for removal of tooth fragment or foreign body]                    | [\$480-1100] |
| [07960] | [Frenulectomy (frenectomy or frenotomy) - separate procedure]                           | [\$90-350]   |
| [07970] | [Excision of hyperplastic tissue – per arch]  | [\$90-350]   |
| [07971] | [Excision of pericoronal gingival]  | [\$30-200]   |
| [07972] | [Surgical reduction of fibrous tuberosity]  | [\$115-400]  |
| [07980] | [Sialodochoplasty]  | [\$140-450]  |

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| <b>[Temporomandibular Joint Services Benefits:</b>   |
| [Temporomandibular Joint Services Benefit Waiting Period: Temporomandibular Joint Services Benefits under this Policy are only payable for covered procedures rendered after[[180-365] calendar days] [1-3] Policy Year[s] from the Effective Date.]   |
| [Benefits for all covered Temporomandibular Joint Services rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [\$100-50,000] [per Covered Person].]  |
| [Benefits for all covered Temporomandibular Joint Services are limited to a maximum lifetime benefit of [\$100-50,000] [per Covered Person]. Once this maximum has been met, no additional Temporomandibular Joint Services Benefits are available [for that Covered Person] under this Policy.] |
| [The Scheduled Benefits shown below will be reduced by [5-100]% for any covered procedure rendered during the first [ [1-3]Policy Year[s]] following the [Effective Date][end of the Benefit Waiting Period].]   |

| <b>Procedure Code</b> | <b>Temporomandibular Joint Services</b>                           | <b>Scheduled Benefit</b> |
|-----------------------|---|--------------------------|
| [00320]               | [Temporomandibular joint arthrogram, including injection]         | [\$130-450]              |
| [07610]               | [Maxilla – open reduction (teeth immobilized, if present)]        | [\$500-600]              |
| [07620]               | [Maxilla – closed reduction (teeth immobilized, if present)]      | [\$485-600]              |
| [07630]               | [Mandible - open reduction (teeth immobilized, if present)]       | [\$500-600]              |
| [07640]               | [Mandible - closed reduction (teeth immobilized, if present)]     | [\$500-600]              |
| [07650]               | [Malar and/or zygomatic arch – open reduction]                    | [\$400-600]              |
| [07660]               | [Malar and/or zygomatic arch – closed reduction]                  | [\$240-600]              |
| [07670]               | [Alveolus – closed reduction, may include stabilization of teeth] | [\$185-600]              |
| [07671]               | [Alveolus – open reduction, may include stabilization of teeth]   | [\$350-600]              |
| [07710]               | [Maxilla – open reduction]  | [\$500-600]              |
| [07720]               | [Maxilla – closed reduction]                                      | [\$500-600]              |
| [07730]               | [Mandible – open reduction]                                       | [\$500-600]              |
| [07740]               | [Mandible – closed reduction]                                     | [\$500-600]              |
| [07820]               | [Closed reduction of dislocation]                                 | [\$115-400]              |
| [07870]               | [Arthrocentesis]  | [\$50-200]               |
| [07880]               | [Occlusal orthotic device, by report]                             | [\$110-400]]             |

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|--|---|
| <b>[Orthodontic Benefits:</b>  |   |
| [Orthodontic Benefits are payable only after satisfaction of the Orthodontic Dental Services Benefit Waiting Period. The Orthodontic Dental Services Benefit Waiting Period is [1-3] Policy Year[s] following the Effective Date of coverage.]   |   |
| [Benefits for all covered Orthodontic Treatment rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [\$100-50,000] per Covered Person.] [Benefits for all covered Orthodontic Treatment rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [\$100-50,000] for all Covered Persons combined.]                      |   |
| [Benefits for all covered Orthodontic Treatment are limited to a maximum lifetime benefit of [\$100-50,000] [per Covered Person]. Once this maximum has been met, no additional Orthodontic Benefits are available [for that Covered Person] under this policy.]   |   |
| [We will pay [actual charges incurred] up to [\$200-600] for the initial Orthodontic Treatment consisting of one or more of the Orthodontic Dental Services listed below. Thereafter a fixed indemnity benefit of \$[200-600] is payable once [every three months] [every month] for continued Orthodontic Treatment involving one or more of the Orthodontic Dental Services listed below.] |   |
| <b>Procedure Code</b>  | <b>Orthodontic Dental Services</b>  |
| [00340]  | [Cephalometric film]  |
| [00350]  | [Oral/facial images (includes intra and extraoral images)]                              |
| [00470]  | [Diagnostic casts]  |
| [08030]  | [Limited orthodontic treatment of adolescent dentition]                                 |
| [08080]  | [Comprehensive orthodontic treatment of the adolescent dentition]                       |
| [08210]  | [Removable appliance therapy]   |
| [08220]  | [Fixed appliance therapy]   |
| [08660]  | [Pre-orthodontic therapy]   |
| [08670]  | [Periodic orthodontic treatment visit (as part of contract)]                            |
| [08680]  | [Orthodontic retention (removal of appliance, construction and placement of retainers)] |

**[AGENT INFORMATION]**

[Name

Address & Telephone Number]

Dental Indemnity Insurance  
Forms Listing

| <u>Form Number</u>   | <u>Form Description</u>                                    |
|----------------------|--|
| 8079.POL.AR          | Dental Policy Cover Page                                   |
| 8079.TOC..XX         | Matrix Insert Section: Table of Contents                   |
| 8079.DEF.AR          | Matrix Insert Section: Definitions                         |
| 8079.DEN.XX          | Matrix Insert Section: Dental Indemnity Insurance Benefits |
| 8079.EXC.XX          | Matrix Insert Section: Exclusions and Limitations          |
| 8079.CLM.AR          | Matrix Insert Section: Claim Provisions                    |
| 8079.PRM.AR          | Matrix Insert Section: Premium Provisions                  |
| 8079.EFF.XX          | Matrix Insert Section: Effective Date and Termination Date |
| 8079.OTH.AR          | Matrix Insert Section: Other Provisions                    |
| 8079.BNS.XX          | Benefit Summary – Dental Insurance                         |
| Form 28565 (10/2009) | Application Form for Dental Insurance                      |
| 8079.OOC.XX          | Outline of Coverage  |

DENTAL INDEMNITY INSURANCE  
OUTLINE OF COVERAGE FOR  
POLICY FORM 8079.POL.XX

THE POLICY PROVIDES LIMITED BENEFITS

THE POLICY PROVIDES COVERAGE FOR DENTAL BENEFITS ONLY AND  
DOES NOT PROVIDE REIMBURSEMENT OF MEDICAL EXPENSES

THIS IS NOT A MEDICARE SUPPLEMENT POLICY

**READ YOUR POLICY CAREFULLY:** This outline of coverage provides a very brief description of the important features of the Policy. This is not the insurance Policy and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both You and Time Insurance Company. It is, therefore, important that You **READ YOUR POLICY CAREFULLY!**

**DENTAL INDEMNITY COVERAGE:** Policies of this category are designed to provide, to the person insured, benefits when specified dental procedures are rendered, subject to any limitations set forth in the Policy and in the amount shown on the Policy Schedule. Coverage is not provided for basic hospital, basic medical-surgical or major medical expenses.

**DENTAL COVERAGE INFORMATION**

[Benefit Waiting Period: Benefits under the Policy[, except Dental Preventive Benefits,] are payable after [30-180] calendar days from the Effective Date [unless as otherwise specified].]

[Basic and Major Services Combined Maximum Benefit Limitation: Benefits for all covered Basic Dental Services and Major Dental Services combined are limited to a maximum Calendar Year benefit of [\$100-50,000] [per Covered Person]. This benefit limitation is in addition to any other maximum benefit limitation specified below.]

**Dental Preventive Benefits:** We will pay one Dental Preventive Benefit of \$[xxx], regardless of the number of visits to a Dentist or Dental Hygienist or the number of services received, every [90-270] calendar days. Dental Preventive Benefits are limited to a maximum benefit of [\$100 - \$50,000] per Calendar Year.

[Basic Dental Services Benefits: We will pay the Scheduled Benefit for Basic Dental Services as show on the Policy Schedule. [The Scheduled Benefit will be reduced by [xx]% for all Basic Dental Services rendered during the first [[180-365] calendar days] [1-2] [Policy Year][s] following the Effective Date of coverage. ] [All benefits for Basic Dental Services rendered during the same Calendar Year are subject to a maximum Calendar Year benefit limitation of \$\_\_\_\_\_.] [All benefits for covered Basic Dental Services are subject to the Basic and Major Services Combined Maximum Benefit.]

[Major Dental Services Benefits: We will pay the Scheduled Benefit for Major Dental Services as show on the Policy Schedule. [The Scheduled Benefit will be reduced by [xx]% for all Major Dental Services rendered during the first [[180-365] calendar days] [1-2][Policy Year][s] following the Effective Date of coverage.] [The Scheduled Benefit will be reduced by [xx]% for all Major Dental Services rendered during the second [[180-365] calendar days] [1-2] [Policy Year][s] following the Effective Date of coverage.] [All benefits for Major Dental Services rendered during the same Calendar Year are subject to a maximum Calendar Year benefit limitation of \$[\_\_\_\_\_].] [All benefits for covered Major Dental Services are subject to the Basic and Major Services Combined Maximum Benefit.]

[Temporomandibular Joint Services Benefits

We will pay the Scheduled Benefit for Temporomandibular Joint Services as show on the Policy Schedule [after a Benefit Waiting Period of [[180-365] calendar days] [1-3] [Policy Year][s]]. [The Scheduled Benefit

will be reduced by [xx]% for all Temporomandibular Joint Services rendered during the first [1-3] [Policy Year][s] following the [Effective Date of coverage][end of the Benefit Waiting Period].] [Thereafter the full Scheduled Benefit will be paid for covered Temporomandibular Joint Services.] [All benefits for Temporomandibular Joint Services rendered during the same Calendar Year are subject to a maximum Calendar Year benefit limitation of \$[\_\_\_\_\_].] [All benefits for Temporomandibular Joint Services are subject to a maximum lifetime benefit limitation of \$[\_\_\_\_\_] per Covered Person.]]

#### [Orthodontic Benefits

[The Orthodontic Dental Services Benefit Waiting Period is [1-3] Policy Year[s] following the Effective Date of coverage.] [Only Covered Persons who are under age [18] years are eligible for Orthodontic Benefits. Orthodontic Treatment must have been initiated prior to the Covered Person's [17<sup>th</sup>] birthday. Benefits for Orthodontic Treatment cease upon attainment of the Covered Person's [18<sup>th</sup>] birthday.] [We will pay benefits for the Orthodontic Dental Services listed on the Policy Schedule when the treatment for Orthodontic Dental Service begins while the Covered Person is insured under the plan. No payment will be made for the Orthodontic Dental Service if the appliances or bands are inserted prior to becoming insured. We consider Orthodontic Treatment to be started on the date the bands or appliances are inserted. Any other Orthodontic Treatment that can be completed on the same day it is rendered is considered to be started and completed on the date the Orthodontic Treatment is rendered.] [We will make a payment for covered orthodontic services related to the initial Orthodontic Treatment, which consists of diagnosis, evaluation, pre-care and insertion of bands or appliances. After the payment for the initial Orthodontic Treatment, benefits for covered Orthodontic Dental Services will be paid in equal [monthly] [quarterly] payments over the course of the remaining Orthodontic Treatment. The initial Orthodontic Treatment and [quarterly] [monthly] indemnity benefit amounts are shown on the Policy Schedule.]

[Benefits for all covered Orthodontic Treatment rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of \$[\_\_\_\_\_] per Covered Person.] [Benefits for all covered Orthodontic Treatment rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of \$[\_\_\_\_\_] for all Covered Persons combined.]

[Benefits for all covered Orthodontic Treatment are limited to a maximum lifetime benefit of \$[\_\_\_\_\_] [per Covered Person]. ]

#### EXCLUSIONS AND LIMITATIONS:

This Policy pays limited, fixed indemnity benefits for Dental Treatments only. See the Policy Schedule for the limited benefit amounts and maximum benefit limitations.

[We will not pay benefits for any of the following:

1. [any procedure or treatment not shown on the Policy Schedule.]
2. [any procedure rendered during an applicable Benefit Waiting Period.]
3. [any amount in excess of a Calendar Year or lifetime maximum benefit limitation.]
4. [Dental Preventive Benefits when there is less than [90-270] calendar days between the dates of service for Dental Preventive Services.]
5. [all Experimental or Investigative Services.]
6. [any procedure performed by a person other than a Dentist or Dental Hygienist.]
7. [any procedure performed by a Covered Person's Immediate Family Member.]
8. [all services that are not Dentally Necessary.]
9. [repairs to dental work less than [30-180] calendar days following completion of the initial procedure.]

10. [prosthetics replaced less than [xx] years following the previous placement.]
11. [crowns replaced less than [xx] years following the previous placement.]
12. [inlays or onlays replaced less than [XXX] years following the last placement.]
13. [dental implants or the removal of implants.]
14. [Cosmetic Services, unless performed to correct a functional disorder.]
15. [services performed outside the United States [and][,] [its territories] [and Canada] except for services that are received for Emergency Dental Treatment.]
16. [replacement of any tooth missing prior to the Effective Date.]
17. [placement of full or partial dentures, whether removable or fixed, including a Maryland Bridge, unless replacing a Functioning Natural Tooth extracted after the Effective Date[and not within a Benefit Waiting Period].]
18. [for Covered Persons under age 16, inlays, onlays, bridgework or crowns except for stainless steel or plastic crowns.]
19. [any charge or procedure for treatment required because of Dental Injury or disease due to:
  - a. [war or any act of war, whether declared or undeclared.]
  - b. [participation in the military service of any country or international organization[,including non-military units supporting such forces.]]
  - c. [charges for Sickness or Injury caused or aggravated by attempted suicide or self-inflicted Sickness or Injury, even if the Covered Person did not intend to cause the harm which resulted from the action which led to the self-inflicted Sickness or Injury.]
  - d. [taking part in a riot or insurrection, or an act of riot or insurrection.]
  - e. [participating in, voluntarily attempting to commit or commission of a felony, whether or not charged, or engaging in an illegal occupation or activity at the time of an Accident.]
  - f. [voluntary use of any controlled substance, as defined by statute, except when administered in accordance with the advice of the Covered Person's health care practitioner.]
  - g. [riding in any aircraft not licensed to carry passengers or not operated by a duly licensed pilot.]
20. [charges for treatment or services required due to an Injury sustained in operating a motor vehicle while the Covered Person's blood alcohol level, as defined by law, was [.08] or higher. This exclusion applies whether or not the Covered Person is charged with any violation in connection with the Accident.]
21. [procedures rendered before the Effective Date or after the termination date of coverage.]
22. [orthodontic treatment and services.]

[In addition to the Exclusions listed above, the following exclusion applies to Orthodontic Dental Services coverage:

We will not pay benefits for Orthodontic Treatment procedures rendered after the Covered Person's [18<sup>th</sup>] birthday.]

**RENEWABILITY PROVISION:** The policy is guaranteed renewable until 12:01 a.m. local time at the Policyholder's state of residence on the earliest of the following dates:

1. the date We receive a request in writing or by telephone to terminate this plan or on a later date that is requested by the Policyholder for termination.
2. the date We receive a request in writing or by telephone to terminate coverage for a Covered

Dependent or on a later date that is requested by the Policyholder for termination of a Covered Dependent.

3. the date this plan lapses for nonpayment of premium per the Grace Period provision in the Premium Provisions section.
4. [the date there is fraud or material misrepresentation made by or with the knowledge of any Covered Person [applying for this coverage or] filing a claim for benefits.]
5. [the date all policies with the same form number as this Policy are non-renewed in the state in which this Policy was issued or the state in which the Policyholder presently resides.]
6. [the date We terminate or non-renew [health][dental] insurance coverage in the individual market in the state in which this Policy was issued or the state in which You presently reside. We will give You advance notice, as required by state law, of the termination of Your coverage.]
7. [[on][t]he date the Policyholder moves to a state where We do not provide insurance coverage under the same plan as this Policy[, We reserve the right to terminate this coverage].]
8. [for a Covered Dependent: on the date a Covered Dependent no longer meets the Dependent definition in this plan.]
9. [the date the Policyholder attains age [65-75] years.] [The anniversary date of this Policy following the Policyholder's [65<sup>th</sup> – 75<sup>th</sup>] birthday.]

|                                      |
|--------------------------------------|
| <b>PREMIUM INFORMATION</b>           |
| Premium Payment Mode: _____          |
| INITIAL MODAL PREMIUM AMOUNT: _____  |
| INITIAL ANNUAL PREMIUM AMOUNT: _____ |

Your premium may be adjusted from time to time based on different factors including, but not limited to, Your geographic area, [gender,] [age,] payment method and plan design. All premium adjustments will be made to individuals on the basis of shared characteristics. The premium may also change if You add or delete Covered Dependents, change the payment method, move to another zip code or otherwise change the coverage.

\_\_\_\_\_  
Licensed Agent's Signature

\_\_\_\_\_  
Date